

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

ORIGINAL

PRINTED: 03/11/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/11/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 20031 A recertification survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/8/16 through 2/11/16. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: F170, F176, F241, F280, F281, F309, F325, F332, and F368.</p> <p>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/8/16 through 2/11/16. Areas surveyed included infection control and nursing services. Golden LivingCenter - Prairie Hills was found in compliance.</p> <p>F 170 SS=C 483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on interview and policy review, the provider failed to ensure mail was delivered to all the residents on Saturdays. Findings include:</p> <p>1. Group interview on 2/9/16 at 10:30 a.m. with sixteen randomly selected residents revealed: *They had not received their mail on Saturdays. *They were unaware they could have mail delivered on Saturdays.</p>	F 000	<p>STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on February 19, 2016. Please accept this plan of correction as the center's Credible Allegation of Compliance with the completion date of March 09, 2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.</p> <p>F170 Send/Receive Unopened Mail</p> <p>No specific residents were identified in the statement of deficiencies.</p> <p>Residents residing in the facility have the potential to be affected in a similar manner.</p> <p>Facility has developed a process to ensure Saturday mail delivery and weekend managers have been educated to the process. Residents will be informed of this process at the next resident council meeting. Not all residents attend Resident Council. Activities is also informing all residents of Saturday Mail delivery.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Bruce Dowdson* TITLE *Executive Director* (X6) DATE *March 4/2016*

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

MAR 24 2016
Facility ID: 0049
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F 170	<p>Continued From page 1</p> <p>*The residents wanted to have their mail delivered on Saturdays.</p> <p>*The postal service delivered the mail to the building on Saturday. No one delivered that mail to the residents.</p> <p>Interview on 2/10/16 at 10:40 a.m. with the activity coordinator revealed:</p> <p>*Mail was delivered Monday through Saturday to the facility.</p> <p>*The activity staff delivered mail to the residents Monday through Friday.</p> <p>*The residents' mail was available for delivery on Saturday.</p> <p>*The current activity person who worked on Saturdays had not been comfortable sorting and delivering the residents' mail.</p> <p>*She agreed the residents should have their mail on Saturday.</p> <p>Interview on 2/10/16 at 2:30 p.m. with the administrator confirmed mail had not been delivered to the residents on Saturdays.</p> <p>Review of the provider's 2/24/15 Mail Service policy revealed "The LivingCenter will provide a mail delivery services and mail sending services within 24 hours of receipt of mail or residents' request to send mail. This includes Saturday delivery."</p>	F 170	<p>F170, continued</p> <p>Executive Director or designee will complete audits weekly x4 then monthly x2 to ensure Saturday mail delivery has occurred and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	03/09/16
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p>	F 176	<p>F176 Self-administration of Drugs</p> <p>Resident #10 has had a Self Administration of Medication Evaluation completed and has been deemed non compliant with policy. Resident has received education related to policy and medications have been removed from his room.</p>	

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F 176	Continued From page 2 This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, and policy review, the provider failed to follow their policy for resident self-administration of medications for one of one sampled resident (10) who had medications at his bedside. Findings include: 1. Observation on 2/8/16 at 4:15 p.m. of resident 10's room revealed he had multiple medications on his bedside table, shelf over his bed, and on the night stand. They included oral, topical, and inhaled medications. Review of resident 10's medical record revealed: *He had been admitted on 6/5/15. *He had a 1/19/16 physician's order "Pt. [patient/resident] may keep OTC's [over-the-counter medications] at the bedside." *A medication self-administration assessment had been completed on 2/3/16 by the director of nursing (DON). The medications listed on a February 2016 medication administration record (MAR) included: Lactaid (for lactose intolerance), Immodium (for diarrhea), and Gas-X. *A care plan focus area for self-medication administration for over-the-counter medications was initiated on 2/2/16. *Interventions for self-medication administration included: -Medications would be stored in a secure location. The location was at bedside in the room. -Noncompliant with keeping bedside medications locked/secure. -Provide reminders of the importance of locking bedside medications.	F 176	F 176, continued Residents residing in the facility who self-administer medications have the potential to be affected in a similar manner. Nursing staff has completed room observations to ensure no medications are in resident rooms. An assessment for self-administration of medications was done on every resident and only one of the residents was interested. New residents admitted to the living center will be educated on the Self-Administration of Medication policy, during the admission process. Those deemed to be capable of self-administration will be asked their preference. The resident who still wished to continue was disqualified, because of non-compliance. Nursing staff have been re-educated on the Self Administration of Medication policy. DON or her designee will complete audits weekly x4 then monthly x2 to ensure residents who self administer medications are in compliance with the policy and will bring results of audits to the monthly QAPI meeting for further review and recommendations.	03/09/16	

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F 176	Continued From page 3 Interview on 2/10/15 at 9:45 a.m. with the DON confirmed: *The self-administration of medication assessment had not been completed until 2/2/16. *Resident 10 had more medications in his room than what was listed on his self-administration MAR. *He did not store them in a secure manner in his room. *His care plan indicated non-compliance with the storage of his medications. Review of the provider's May 2012 Self-Administration of Medications policy revealed: *If the resident desired to self-administer medications: -An assessment would have been conducted by the interdisciplinary team before self-administration of medication would have been allowed. -If the resident demonstrated the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage would have been conducted. -The resident would have been asked to complete a bedside record that indicated the administration of the medication.	F 176			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241	F241 Dignity Certified nursing assistant J and another C N A were immediately suspended pending further investigation. A thorough investigation was completed and findings were submitted to the South Dakota Department of Health.		

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Surveyor: 14477 Based on observation, interview, policy review, and record review, the provider failed to ensure personal care was provided in a dignified manner for two of seven (2 and 6) sampled residents. Findings include: 1. Interview on 2/9/16 at 4:15 p.m. with resident 2 revealed she had awakened in the night a couple of nights ago with a stomach ache. She wanted to use the toilet to have a bowel movement (BM) and had put her call light on. When the unidentified traveling certified nursing assistant (CNA) came into her room she was told in a "mean" manner to have the BM in her brief. The CNA told her it would be quicker to clean up the BM in the brief then to take the time to toilet her. The CNA stated they were short staffed. Resident 2 revealed she did not want to have the BM in her brief, but she just had to and it made her "feel bad." Resident 2 also stated she had told another CNA, whose name she could not recall, about the incident but had not shared it with anyone else. Record review of the 11/20/15 Minimum Data Set (MDS) assessment for resident 2 revealed she had a Brief Interview for Mental Status (BIMS) score of 15 that meant she was cognitively intact at the highest level. Review of the facility Dignity policy SS 702 with an effective date of 2/16/15 revealed: "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality."	F 241	F 241, continued All Nursing Assistants and Nurses were required to attend the in-service. Those who could not attend were required to review the notes from the meeting, and to complete a worksheet to demonstrate understanding. No staff will be allowed to return to duty without reviewing these materials. C N A's D and E attended in-services designed to address the deficiencies, including F-241. An observation of care will be completed to determine compliance. Residents residing in facility have the potential to be affected in a similar manner. Staff has been re-educated on the dignity policy. Director of nursing or designee will complete 5 random audits weekly x4 then monthly x2 to ensure residents dignity is preserved and will bring results of audits to the monthly QAPI meeting for further review and recommendations.	03/09/16
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F 241	<p>Continued From page 5</p> <p>Review of the 2/7/16 Activities of Daily Living (ADL) Detail Report log for resident 2 revealed an entry by traveling CNA J at 3:16 a.m. that stated:</p> <p>*For Resident/Patient's Level of Self Performance: "Total Dependence, I did 100% - the Resident did nothing."</p> <p>*Under the question: "Did you use a Mechanical Lift to transfer resident on/off toilet, bedpan or bedside commode?", the CNA had documented "No - I did not use a Mechanical Lift to transfer resident on/off toilet, bedpan or beside commode."</p> <p>*Under the question: "How much toileting help did you provide"?, the CNA had documented "one person physical assist."</p> <p>Interview on 2/10/16 at 9:10 a.m. with the ADON (assistant director of nursing) regarding resident 2's interview revealed they were not short staffed. She stated being told to have the BM in the brief "was not acceptable!" Further interview on 2/10/16 at 3:05 p.m. with the ADON revealed the facility was doing an investigation into the above incident with resident 2.</p> <p>Surveyor: 36413</p> <p>2. Observation on 2/8/16 from 8:30 a.m. through 9:10 a.m. in resident 6's room revealed:</p> <p>*The resident's bed was by the door.</p> <p>*Certified nurse aide (CNA) D was providing personal care for the resident.</p> <p>*The privacy curtain was not closed around the resident's bed to provide privacy when the door to the room was opened.</p> <p>-An unknown staff member opened the door to the resident's room and spoke with CNA D.</p> <p>-CNA D went out of the resident's room two times.</p> <p>-CNA E opened the door twice.</p>	F 241			

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F 241	Continued From page 6 --All of those times the door had been opened the resident was laying in bed wearing only a brief. The resident had been exposed to other staff, residents and visitors in the hall.	F 241			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review, and policy review, the provider failed to ensure 1 of 19 sampled resident's (21) care plan had been reviewed and revised to reflect the resident's infection control precautions. Findings include:	F 280	F280 Right to Participate in Planning Care-Revise CP Care plan for resident #21 has been reviewed and revised to reflect resident's current status. All residents residing in the facility have the potential to be affected in a similar manner. Department managers and nursing staff have been re-educated on the care plan process. Care plans will be reviewed and revised during daily clinical start up with resident condition changes to accurately drive the resident's care. Comprehensive care plans will be reviewed and revised during the next resident MDS assessment. Director of nursing or designee will complete 5 random audits weekly x4 then monthly x2 to ensure residents care plan accurately reflects the resident's current care needs and will bring results of audits to the monthly QAPI meeting for further review and recommendations.		

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F 280	<p>Continued From page 7</p> <p>1. Observation on 2/9/16 at 10:00 a.m. and on 2/10/16 at 8:00 a.m. revealed a red garbage can located inside resident 21's room. There was a isolation supply holder hanging on the inside of her door.</p> <p>Review of resident 21's medical record revealed: *No interdisciplinary notes indicated she had MRSA(methicillin resistant staphylococcus aureus) in her urine. *No physician's orders for any isolation precautions.</p> <p>Interview on 2/10/16 at 9:45 a.m. with the director of nursing (DON) revealed: *Resident 21 had MRSA in her urine. *The DON was asked where that diagnosis could be found in resident 21's medical record. *At 10:30 a.m. on that same day the DON found the diagnosis UTI (urinary tract infection) MRSA on a 1/1/16 physician's hospital discharge summary. *She agreed there was no indication in the interdisciplinary notes or on her care plan that she had MRSA in her urine.</p> <p>Review of resident 21's 12/11/15 care plan revealed no problem, goal, or interventions related to her urinary MRSA or the contact isolation precautions that were being followed.</p> <p>Review of the provider's 8/20/15 RAI (Resident Assessment Instrument) Process policy revealed the provider would have utilized The Center for Medicare and Medicaid Services: Long Term Care Facility Resident Assessment Instrument User's Manual for the development of the comprehensive plan of care.</p>	F 280	<p>F 280 continued</p> <p>The week before survey, care plans were assessed for at least fifteen residents. Prior to making all of the corrections, the survey was conducted. Following survey, every resident's care plan will be audited again.</p> <p>The start-up meeting is designed to highlight residents who are having a change in condition. Findings are used to focus attention on the issues.</p> <p>All comprehensive resident care plans are reviewed and revised during the MDS assessment.</p>	03/09/16	

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F 281 F 281 SS=E	Continued From page 8 483.20(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: 36413 A. Based on observation, interview, record review, and policy review, the provider failed to follow midline peripherally inserted central catheter (PICC) care for two of three sampled residents (7 and 14). Findings include: 1. Observation on 2/9/16 at 11:30 a.m. of licensed practical nurse (LPN) C in resident 7's room revealed the resident's midline PICC dressing was dated 1/30/16. Interview on 2/9/16 at 11:30 a.m. with LPN C revealed: *Resident 7's midline PICC dressing change should have been done before today (2/9/16). *She was not sure how often the dressing should be changed. *She did not have a current order to flush the midline PICC line. *She would contact the physician for orders regarding the above issues. Review of the resident's complete medical record revealed: *The antibiotic given through the midline PICC intravenously (IV) (directly into the bloodstream) had been completed on 2/3/16. *The last time the midline PICC had been flushed was when the last dose of antibiotic had been	F 281 F 281	F281 Services Provided Meet Professional Standards A Residents #7 and #14 have had their PICC lines discontinued per physician's order. One other resident had a PICC line. Residents residing in the facility with PICC lines have the potential to be affected in a similar manner. Residents who have PICC lines have been audited and physician orders obtained to appropriately manage the care of the PICC line per policy. Licensed nursing staff have been re-educated on the PICC line policy. The process matches the policy. New resident admissions and current residents with new orders for PICC lines will be reviewed at daily clinical start up to ensure PICC line policy is being followed. Director of nursing or designee will complete 2 random audits weekly x4 then monthly x2 to ensure PICC line policy is being followed. The DON or her designee will bring results of audits to the monthly QAPI meeting for further review and recommendations.	

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F 281	<p>Continued From page 9 given on 2/3/16. *No new orders had been added to the resident's medication administration record (MAR) since completion of the antibiotic.</p> <p>Surveyor: 29162 2. Review of resident 14's medical record revealed she had been admitted on 2/3/16. She had a midline PICC for IV medication administration.</p> <p>Observation on 2/10/16 at 8:00 a.m. of resident 14's midline PICC insertion site dressing revealed a clear dressing with no visible date recorded on it. Per the resident's treatment administration record and MAR that dressing had not been changed. The midline PICC insertion site had gone eight days without a dressing change.</p> <p>Surveyor: 36413 3. Interview on 2/10/16 at 2:35 p.m. with the director of nursing revealed: *She would have expected the dressing to be changed according to their policy. *The nurse who gave the last antibiotic should have received orders from the doctor and added the orders to the MAR for flushes and dressing changes.</p> <p>Review of the provider's May 2012 Midline Dressing Changes policy revealed: *Change midline catheter dressing every five days or if it is wet, dirty, not intact, or compromised in any way. *Flush at least once every twenty-four hours to prevent occlusion (blockage). Surveyor: 26632 B. Based on record review, interview, and policy review, the provider failed to ensure the physician</p>	F 281	<p>F281 Services Provided Meet Professional Standards – Notification of Change</p> <p>B No corrective action can be taken for Resident #12 as they have been discharged.</p> <p>All residents have the potential to be affected by the alleged deficient practice.</p> <p>The policy on, "Notification of Change in Resident Health Status," has been reviewed with Nursing Personnel at meetings held on March 3, 2016.</p> <p>At weekday 'start-up' meetings staff will identify residents who have a change in status.</p> <p>The Director of Nursing or her designee will review notes from meetings weekly for 4 weeks and then monthly for two months. The charts of two residents with a status change will be audited to ensure proper notifications of change are completed. The DON or her designee will report results to the QAPI Committee.</p>	03/09/16

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F 281	<p>Continued From page 10</p> <p>was notified in a timely manner for one of one sampled residents (12) who had a change in condition. Findings include:</p> <p>1. Review of resident 12's interdisciplinary progress notes revealed: *1/10/16 at 9:54 a.m. "Resident bilat [both] lower legs are weeping with fluids noted, wrap with kerlex [dressing] encourage to elevate his legs resident appears very confused unable to stay in bed staff help resident several times but resident won't stay report receive from previous shift resident was up since 0400 [4:00 a.m.] this AM. Will notify primary MD [medical doctor], awaiting for response report given to oncoming shift." *1/10/16 at 9:26 p.m. "Resident bilat leg are edematous [swelling] with weeping fluids noted." *1/11/16 at 3:27 a.m. "Resident having increased swelling to lower ext's [extremities - legs] and increased confusion. He is also non compliant to PO [oral] meds [medications] and has loose stools. Dr. _____ call and new order received to send resident to ER [emergency room] for evaluation." *1/11/16 at 8:21 a.m. "Called [hospital] to check status of resident and he was admitted for Sepsis [severe infection], UTI [urinary tract infection], and A-Fib [atrial fibrillation heart not beating correctly]."</p> <p>Review of a 1/10/16 at 9:54 p.m. facsimile communication to resident 12's physician revealed: ""Resident bilat leg are edematous with weeping noted, encourage resident to elevate his legs but non-compliant. Bilat lower leg wraps with kerlex at this time. May we get an order for lymphedema wrap [special wrap to decrease swelling] or pls [please] advise."</p>	F 281			

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F 281	Continued From page 11 *The physician responded on 1/11/16 at 5:09 p.m."I would have preferred to be called about this at 10 pm instead of 3:30 a.m. (instead of being faxed)." Interview on 2/10/16 at 9:45 a.m. with the director of nursing revealed: *Her expectation was the physician would have been called with a significant change in condition. *The physician should not have been faxed at that time of day when a reply would have been expected sooner. Review of the provider's 11/12/14 Notification of Change in Resident Health Status policy revealed: *The provider would consult with the resident's physician, nurse practitioner, or physician assistant when there was an acute illness or a significant change in the resident's physical, mental, or psychosocial status. *The criteria for a life threatening condition included the onset or recurrent periods of delirium (increased confusion). *"Nursing judgment is an integral part of the skilled care provided in this LivingCenter; therefore, such judgment must be applied in a case by case basis in keeping with acceptable nursing practice."	F 281			
F 309 SS=D	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.	F 309	F309 Necessary Care for Highest Practicable Well Being Resident #/was interviewed and chooses to stay in same clothing until she decides to have clothing changed. Care plan has been reviewed and revised to reflect this personal choice.		

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F 309	Continued From page 12 This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, interview, record review, and policy review, the provider failed to ensure a treatment was completed and the individual needs were met for of one of one (1) bedfast resident reviewed. Findings include: 1. Observations on 2/9/16 of resident 1 in bed in her room revealed: *At 7:45 a.m. she was laying on her back. The head of her bed had been elevated approximately forty-five degrees (sitting half way up). Her legs were laying on a pillow that had been placed lengthwise. Her heels were not touching the mattress. She had on a pink short sleeved sweater and blue cotton-like slacks. The corner of the sheet on the head-of-the-bed on her right side was loose and hung down below her shoulder. *At 10:00 a.m. she was still laying on her back. The head of her bed was still elevated approximately forty-five degrees. Her legs were still elevated on a pillow that had been placed lengthwise. Her heels were not touching the mattress. She still had on a pink short sleeved sweater and blue cotton-like slacks. Her slacks had slid up around both of her knees. The sheet was still off the top of her bed and hung down below her right shoulder. *At 11:48 a.m. the head of her bed had been raised to about ninety degrees (sitting upright). The sheet was still off the top of the bed and hung below her right shoulder area. She had on the same clothes and her left heel was laying on the bed. Her slacks were slid up around her	F 309	F 309, continued Residents residing in the facility have the potential to be affected in a similar manner. Residents with similar choices will be interviewed and care plans will be reviewed and revised to reflect those personal choices. In-service provided on positioning, proper attire and bed-making. Catheter care was also discussed. Wrinkled linens were also talked about from a dignity perspective and from a skin integrity perspective. Education provided to Nurses and Aides Staff has been reeducated on resident's right to make personal choices. Director of nursing or designee will complete 2 random audits weekly x4 then monthly x2 to ensure residents have been interviewed relating to personal choice. Audits will also verify that the care plan has been reviewed and revised to reflect personal choices. Results of audits will be brought to the monthly QAPI meeting by the DON or her designee, for further review and recommendations.	03/09/16	

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F 309	<p>Continued From page 13</p> <p>knees. The pillow case on the pillow under her legs was off about three-fourths of the way and exposed the blue plastic of the pillow. Her lower legs laid directly on that blue plastic.</p> <p>*At 3:40 p.m. she was in the same position. She had on the same clothes. The pillow case remained off of the pillow. Her lower legs still laid on the blue plastic cover of the pillow.</p> <p>*At 4:15 p.m. there were still no changes in her position, her clothing, or the pillow.</p> <p>Observations of resident 1 on 2/10/16 at 7:30 a.m. and at 10:00 a.m. while she was in her room revealed she was laying in bed on her back. She had on the same pink short sleeved sweater and blue cotton like slacks that she had on above. There was a folded night gown laying at the foot of her bed.</p> <p>Review of resident 1's 1/11/16 Minimum Data Set assessment revealed she had moderate cognitive (orientation) impairment according to her Brief Interview for Mental Status score. She required extensive assistance of one for bed mobility (positioning and moving in bed), dressing, and personal hygiene (grooming).</p> <p>Review of resident 1's current care plan revealed a focus area (problem area) for a physical functioning deficit (unable to care for self). Interventions had been extensive assistance of one for dressing and personal hygiene, bed mobility, and changing position in bed.</p> <p>Review of the CORP-ADL Detail Report (nurse aide charting) documented by the nurse aides revealed no bed mobility assistance, dressing assistance, or personal hygiene assistance had been documented from 3:23 a.m. until 6:59 p.m.</p>	F 309			

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F 309	<p>Continued From page 14 on 2/9/16.</p> <p>Interview on 2/10/16 at 9:50 a.m. with the second floor social service assistant regarding resident 1 revealed she expected "All cares to have been provided for her every morning and evening." She agreed the resident had on the same clothes for more than twenty-four hours.</p> <p>Interview on 2/10/15 at 10:20 a.m. with the second floor resident care coordinator revealed she stated resident 1 sometimes refused her care. She stated her expectation when and if the resident refused her care was for the nurse aides to approach the resident later. If they still were unable to provide care for the resident they were to report the care refusal to the floor nurse or to herself.</p> <p>2. Review of resident 1's treatment administration record revealed an order for catheter care every shift.</p> <p>Interview on 2/9/16 at 4:00 p.m. with registered nurse (RN) H revealed she had not provided catheter care for resident 1 during the day shift. She stated the nurse on the floor "would do that."</p> <p>Interview on 2/9/16 at 4:05 p.m. with RN I revealed she had not provided catheter care for resident 1 during the day shift. She stated RN H was doing wound care, and she would have provided the catheter care.</p> <p>Second interview on 2/9/16 with RN H at 4:10 p.m. revealed either the RN or aides could provide the catheter care for resident 1. She stated "RN I might know who did it."</p>	F 309			

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F 309	Continued From page 15 Review of resident 1's current care plan revised on 1/28/16 revealed she had a focus area of an indwelling catheter. Care was to have been provided for the catheter every shift and as needed. Interview on 2/10/16 at 10:20 a.m. with the second floor resident care coordinator revealed she expected the floor nurses to know who had provided catheter care for resident 1. She stated the nurses would document the care but did not always complete that care themselves. Review of the provider's Catheter Care, Indwelling Catheter policy last reviewed on 12/1/15 revealed the purpose had been to prevent infection and reduce irritation. It had not stated who would have been responsible for the catheter care.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Surveyor: 14477	F 325	F325 Maintain Nutrition Status/Therapeutic Diet – Residents #7 and #9 have been reweighted. RD and physician have been notified of current status and appropriate interventions have been started to maintain or prevent any further weight loss. Care plan has been reviewed and revised. Residents residing in the facility experiencing weight loss have the potential to be affected in a similar manner.	

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F 325	<p>Continued From page 16</p> <p>Based on observation, interview, and record review, the provider failed to give nutritional care in keeping with a resident's change in condition for two of two residents (7 and 9) reviewed for weight concerns. Findings include:</p> <p>1. Observation on 2/9/16 at 12:10 p.m. of resident 9 revealed a lunch room tray was delivered to his room. He was being assisted from the bed to a wheelchair by two staff. He was sitting up in a wheelchair and was offered assistance with the meal that he declined. He repeatedly yelled "Help me, help me, help me" to which staff responded by offering a glass of lemonade. He drank three glasses of lemonade and refused to eat the noon meal. He was assisted back into bed without eating.</p> <p>Review of resident 9's medical record revealed a hospital admission on 1/12/16 for a right toe amputation with a discharge back to the facility on 1/25/16.</p> <p>Review of resident 9's February 2016 Medication Administration Record (MAR) revealed he was not receiving any diuretics for fluid retention.</p> <p>Review of resident 9's medical record revealed weights of: *On 7/28/15 of 209 pounds (lb). *On the 10/16/15 Minimum Data Set Assessment (MDS), 209 pounds. *No weight recorded for November 2015. *On 12/14/15, 208.2 lb. *On the 2/1/16 MDS, 173 lb. That equated to a weight loss of 36 pounds in three months, 10/16/15 to 2/1/16. *That weight loss would be considered a severe weight loss of greater than 10 percent of body</p>	F 325	<p>F 325, continued</p> <p>Residents have been weighed and evaluated for weight loss. RD and physicians have been notified of any significant weight loss and appropriate interventions have been started to maintain or prevent any further weight loss. Care plans have been reviewed and revised. Residents weights will be reviewed in daily clinical start up meetings with appropriate referrals and follow up initiated.</p> <p>Nursing staff have been reeducated on weight policy and notification of RD and physician.</p> <p>Director of nursing or designee will complete 5 random audits weekly x4 then monthly x2 to ensure residents have been weighed and weight policy is being followed. Results of audits will be brought to the monthly QAPI meeting, by DON or her designee, for further review and recommendations.</p>	03/09/16

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F 325	<p>Continued From page 17 weight.</p> <p>*No re-weights were documented in the weight log.</p> <p>Interview on 2/10/16 at 10:00 a.m. with the dietary manager (DM) revealed she:</p> <p>*Had sent a text to the registered dietician (RD) regarding resident 7 but had not heard back from him.</p> <p>*Knew resident 7 had been hospitalized for a toe amputation and needed to have additional zinc, vitamin C, and extra protein to promote wound healing.</p> <p>*Knew resident 7 had some edema (fluid retention), and that had been some of the weight loss that had occurred when he was recently hospitalized.</p> <p>*Had put no new dietary interventions in place since he had returned from the hospital.</p> <p>Interview on 2/10/16 at 10:15 a.m. with the RD referenced above revealed he:</p> <p>*Had resigned his position with the facility effective 1/15/16, and that had been his last day.</p> <p>*Had been moved to "casual" status by the facility.</p> <p>*That meant he would assist the provider only if he had time.</p> <p>*Had not been in the facility since 1/15/16 and had not had time to assist the facility.</p> <p>*Was not aware of resident 7's toe amputation, weight loss, or the need for changes to his diet.</p> <p>Surveyor: 20031</p> <p>Interview on 2/10/16 at 11:15 a.m. with the assistant director of nursing (ADON) revealed the DM had spoken with her regarding resident 7. The ADON stated the DM told her she had sent numerous messages to the RD regarding the status of resident 7 but had not heard from him.</p>	F 325			

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F 325	Continued From page 18 When questioned if the DM knew the RD had resigned his position from the provider effective 1/5/16, the ADON stated the DM might not have been informed by the administrator the RD had resigned. Surveyor: 36413 2. Review of resident 7's medical record revealed: *Weight discrepancies between three to five pounds for the last weight, was not re-weighed to prove accuracy of the scale and the current weight. *On 1/13/16 the weight was 102.2 pounds, and the previous weight had been 108.8 pounds. *On 1/28/16 the weight was 102.5 pounds and previous weight had been 108.8 pounds on 1/20/16. The facility was unable to provide a policy or procedure upon request for doing reweighs when there were weight discrepancies.	F 325			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 14477 Based on observation, interview, and competency policy review, the provider failed to ensure insulin injections were administered with no greater than a five percent error rate for two of two (22, and 23) observations of insulin injections. The facility medication administration error rate was eight	F 332	F 332 Medication Error Rates of 5% or More No corrective action could be taken for resident #22 and #23 as the event is in the past. Residents residing in the facility who receive insulin via an insulin pen have the potential to be affected in a similar manner. Resident audits are to include competency of nursing staff.		

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F 332	<p>Continued From page 19 percent. Findings include:</p> <p>1. Observation on 2/9/16 at 7:20 a.m. revealed licensed nursing staff A administered Levemir insulin with a flex pen to resident 22 without first priming the needle. The needle was immediately withdrawn after the administration.</p> <p>2. Observation on 2/9/16 at 8:03 a.m. revealed licensed nursing staff B administered Lantus insulin with a flex pen to resident 23 without priming the needle. The needle was immediately withdrawn after the administration.</p> <p>3. Review of the Levemir insulin pen competency policy revealed: ***Steps 9-15 Action: Dials a test dose of 2 units. Holds the pen up and taps to bring any bubbles to the top. Presses the INJECT button all the way and checks that insulin has come out of the needle. The dial will return to "0" if this occurs...Once primed, checks window is reading "0". Dials in ordered dose (units)...Cleans selected injection site with alcohol swab. Injects dose, keeping needle at 90*(degree) angle to UN-pinched skin, keeping needle in place and counting to 6 seconds, ensuring dose window reads "0." Releases button after 6 seconds and removes needle."</p> <p>Review of the Lantus insulin pen competency policy revealed: ***Steps 9-15 Action: Dials a test dose of 2 units. Holds the pen up and taps to bring any bubbles to the top. Presses the INJECT button all the way and checks that insulin has come out of the needle. The dial will return to "0" if this occurs...Once primed, checks window is reading "0." Dials in ordered dose (units)...Cleans</p>	F 332	<p>F 332, continued</p> <p>Licensed nursing staff has been reeducated on the administration of insulin via insulin pen protocol. Staff members A and B were included in this education.</p> <p>Director of nursing or designee will complete 2 random audits weekly x4 then monthly x2 to ensure residents insulin pen administration protocol is being followed and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	03/09/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702		
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F 332	Continued From page 20 selected injection site with alcohol swab. To inject dose plunges needle at 90* angle to UN-pinched skin, keeping needle in place and counts to 10 seconds. Releases button after 10 seconds and removes needle." Interview on 2/11/16 in the morning with the assistant director of nursing confirmed insulin pens needed to be primed with two units and the needle held in place in ensure the full dose was received before withdrawing the needle.	F 332			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on group interview and policy review, the provider failed to offer all residents a bedtime	F 368	F 368 Frequency of Meals No specific residents were identified in the statement of deficiencies. Residents residing in the facility have the potential to be affected in a similar manner. Executive Director and Director of Nursing Services have reviewed current facility practice of providing HS snacks for residents. Facility system has been developed to ensure HS snacks are offered to all residents. Nursing and Dietary staff have been reeducated to ensure HS snacks are offered to all residents. Director of nursing or designee will complete 2 random audits weekly x4 then monthly x2 to ensure residents are being offered HS snacks. Results of audits will be brought to the monthly QAPI meeting, by the DON or her designee, for further review and recommendations.	03/09/16	

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F 368	<p>Continued From page 21 snack. Findings include:</p> <p>1. Group interview held on 2/9/16 at 10:30 a.m. with sixteen randomly selected residents revealed: *Bedtime snacks were brought to the nurses' desk on a tray and left there by dietary. *Those snacks were not taken room-to-room and offered to every resident. *If the residents wanted a snack they had to go to the desk and get it. *There were no drinks offered with the snack. *Eight of the random residents at the group meeting would have liked a bedtime snack. -They stated they would have taken a snack if it had been offered to them in their rooms.</p> <p>Interview on 2/10/16 at 2:00 p.m. with the certified dietary manager confirmed the dietary staff delivered the bedtime snack to the nurses' station between 7:00 p.m. and 7:30 p.m. The only drink offered was water. Thickened liquids were available for residents with special diets.</p> <p>Interview on 2/10/16 at 10:20 a.m. with the second floor resident care coordinator revealed she had been unsure if every resident had been offered a bedtime snack.</p> <p>Review of the provider's 2/12/15 Dining Services Nourishments policy revealed "Nourishments are foods and beverages offered to all patients on a routine basis at hour of sleep (HS) unless contraindicated by diet. "</p>	F 368			

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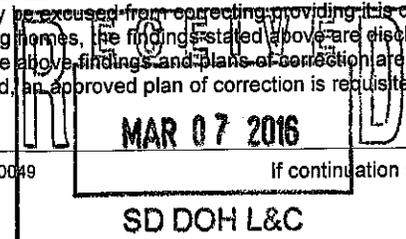
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702
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K 000	<p><i>*Addendums noted with an asterisk per 3/9/16 per CHV/SDDOH L</i></p> <p>INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/09/16. Golden LivingCenter - Prairie Hills was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029, K038, and K051 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on February 11, 2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of March 9, 2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas (basement elevator hydraulic room). Findings include:</p> <p>1. Observation at 1:45 p.m. on 2/09/16 revealed the elevator hydraulic room in the basement had a corridor door that was not equipped with a</p>	K 029	<p>K 029 Door Closers</p> <p>All residents have the potential to be affected by the alleged deficiency.</p> <p>Door closers have been installed on the elevator hydraulic room.</p> <p>The monthly inspection checklist will be revised to include the observation for proper operation of door closers on all hazardous areas in the building.</p> <p>Hazardous areas will be inspected weekly for four weeks and then monthly for an additional two months.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce Bowles</i>	TITLE <i>ED</i>	(X6) DATE <i>03/04/2016</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 029	Continued From page 1 closer. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiency affected one of several hazardous areas in the building required to be provided with self-closing doors to the corridor. Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.1(3)	K 029	K 029, continued The Maintenance personnel will conduct these inspections and results will be reported to the QAPI Committee. <i>*The checklist is completed monthly and reported monthly, CKV/SDD/HJL</i>	03/09/16
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one of five ground floor exits (northeast exit discharge). Findings include: 1. Observation at 9:15 a.m. on 2/09/16 revealed the northeast wing exit discharge on the east side of the building had a landing that ended approximately 15 feet from the nearest paving. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated that condition had existed for many years. The deficiency had the potential to affect all 26 residents in that smoke compartment. B. Based on observation, testing, and interview, the provider failed to ensure one of three exits on the ground floor (southeast door exit) was readily accessible at all times. Findings include:	K 038	K 038 Exit Access All residents have the potential to be affected by the alleged deficiency. Bids have been received for paving the exit discharge area from the exit to a paved, public walkway. The exit door hardware has been adjusted to assure that the panic bar does release the magnetic lock when an appropriate force is applied. The monthly inspection checklist will be revised to include a check of the lock releasing mechanisms on all magnetic locking doors. The checklist will also include observation of paved surfaces from exits to a paved, public walkway. Exits will be inspected weekly for four weeks and then monthly for an additional two months. The Maintenance personnel will conduct these inspections and results will be reported to the QAPI Committee. <i>*The checklist is completed monthly and reported monthly, CKV/SDD/HJL</i>	03/09/16

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K 038	Continued From page 2 1. Observation at 8:30 a.m. on 2/09/16 revealed the southeast exit door was equipped with a magnet lock and delayed egress signage. Testing of the door at the time of the observation revealed the door release was not activated by firmly pushing against the panic bar. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Subsequent testing of the door by maintenance staff revealed pushing on the panic bar with excessive force did activate the magnetic lock release. The deficiency had the potential to affect all occupants in that smoke compartment. Ref: 2000 NFPA 101 Section 19.2, 7.2.1.6.2 NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 051 SS=F	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically	K 051	K 051 Alarm System All residents have the potential to be affected by the alleged deficiency. Bids are being requested for replacement of the Fire Alarm System. Alarm signals are working properly and the monitoring company is receiving those signals. Supervisory signals are not working. The new system will allow all signals to transmit to the monitoring company. The monthly inspection checklist will be revised to include verification that alarm signals are continuing to be received by the monitoring company. <i>*during fire drills, verifications will be conducted</i> <i>monthly for</i> <i>months. The Maintenance personnel will conduct these verifications and results will be reported to the QAPI Committee. → See next page</i>	03/09/16

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K 051	<p>Continued From page 3</p> <p>activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>Based on document review and interview, the provider failed to maintain the fire alarm system (the fire alarm panel [FAP] did not send supervisory signals as required). Findings include:</p> <p>1. Review of the fire alarm system documentation at 10:00 a.m. on 2/09/16 dated 11/03/15 indicated supervisory signals had not been transmitted to the central monitoring station. The comment entered on the report stated "This needs to be repaired."</p> <p>Review of the fire alarm system documentation dated 1/06/15 stated notifications were not working. It stated that eight supervisory (signals) should have gone out but had not. Review of documentation dated 11/03/15 stated the monitoring company did not receive any supervisory signals. They did receive alarm signals. The monitoring company should be receiving all signals. This needs to be repaired.</p> <p>Interview with the maintenance supervisor at the time of the document review revealed he was aware of the non-transmission of the supervisory signals. He said he had discovered one of the circuit boards for the fire alarm panel was bad and needed to be replaced.</p> <p>The deficiency had the potential to affect all occupants of the building.</p>	K 051	<p><i>*as verifications are made and is a monthly report.</i></p> <p><i>CHV/SDD/HJEL</i></p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW RD RAPID CITY, SD 57702
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Medical Facilities, requirements for nursing facilities, was conducted from 2/8/16 through 2/11/16. Golden LivingCenter - Prairie Hills was found not in compliance with the following requirements: S169, S206, and S322.</p>	S 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on February 11, 2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of March 9, 2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
S 169	<p>44:73:02:18(5-7) Occupant Protection</p> <p>The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for four of six exterior doors (southeast exit, main entrance, courtyard exit, and exit to the service wing). Findings include:</p>	S 169	<p>S 169 Door Alarms</p> <p>All residents have the potential to be affected by the alleged deficiency.</p> <p>Codes above exit doors have been removed. The electrically activated audible alarm for unattended doors has been reactivated.</p> <p>The monthly inspection checklist will be revised to include verification that unattended doors are alarmed.</p> <p>Verifications will be conducted weekly* by the for four weeks and then monthly for an additional two months. The Maintenance</p>	<p>CHV/SDDOHTJEL</p>

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

[Signature]

STATE FORM 6899 MROL11

TITLE _____ (X6) DATE _____

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Continuation sheet 1 of 5

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10669	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2016
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S 169	Continued From page 1 1. Observation and testing from 8:00 a.m. through 8:30 a.m. on 2/09/16 revealed the southeast exit door was equipped with a delayed egress magnetic lock. That door would also unlock if the proper code was typed into a keypad. The code to unlock the door was posted on a sign beside and above that door. Once the proper code was entered the magnetic door lock would release. When the door was opened the alarm did not sound. The posted code would allow residents to input the code and leave the building without sounding the door alarm. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He stated the main entrance, courtyard exit, and service wing exit all were similarly configured. He stated a wander management system was also in place for certain assessed residents.	S 169	S 169, continued personnel will conduct these verifications and results will be reported to the QAPI Committee.	03/09/16
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory	S 206	S 206 Personnel Training All residents have the potential to be impacted when personnel do not complete required annual training. Education has been made available on the Learning Center. Staff who have not completed their annual training will be notified in writing that they must complete the training. A deadline for completing the training will be included in the notice. The notice will also list specific courses which they must complete. Employees failing to complete the required courses will be suspended.	

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S 206	<p>Continued From page 2</p> <p>reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment.</p> <p>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29162</p> <p>Surveyor: 36413 Based on record review and interview, the provider failed to ensure required yearly staff in-service education was completed for ten of ten randomly selected employees (C, D, E, I, K, L, M, N, O, P). Findings include:</p> <p>1. Review of the provider's list of all staff training completed during the last year revealed: *All required annual training had not been completed for all ten of the randomly reviewed employee education records. *All of those ten employees had worked for the provider more than one year.</p>	S 206	<p>S 206, continued</p> <p>The monthly education completion report will be monitored by Director of Education. This has been completed for the month of February. This will be monitored monthly for the next three months. Results will be reported to ED, DNS and the QAPI Committee.</p> <p>Staff has been re-educated on the importance of timely completion of required education.</p> <p><i>*Results of audits will be brought to the monthly QAPI meeting for further review and recommendations. CHV/SDPOTT/EL</i></p>	03/09/16
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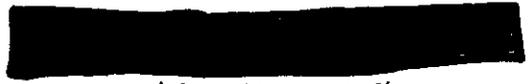
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10669	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW RD RAPID CITY, SD 57702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	<p>Continued From page 3</p> <p>Interview on 2/10/16 at 4:30 p.m. with the director of clinical education revealed: *She was responsible for maintaining the records for the provider's inservice training. *She confirmed the inservices were not done. *She was not responsible for making sure everyone had completed the on-line inservices.</p> <p>Interview on 2/10/16 at 11:15 a.m. with the assistant director of nursing regarding the required in-services revealed: *The courses were online and staff were to complete those tasks on their own. *She agreed the mandatory inservices were to be completed by all staff. *She thought the director of clinical education had been responsible to make sure all annual education was completed by the employees.</p> <p>Interview on 2/11/16 8:00 a.m. with the nurse consultant agreed the education was not done yearly. No specific person was in charge of seeing that all employees completed the on-line mandatory inservices or complete training.</p>	S 206		
S 322	<p>44:73:08:05 Control and Accountability of Medications</p> <p>Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication shall be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from their receipt through administration, destruction, or return.</p>	S 322	<p>S 322 Control and Accountability of Medications</p> <p>Resident #18 was discharged therefore facility is unable to correct</p> <p>Residents being discharged from the facility have the potential to be affected in a similar manner.</p> <p>Licensed nursing staff has been reeducated on the resident discharge with medication protocol.</p>	

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PRAIRIE HILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 916 MOUNTAIN VIEW RD RAPID CITY, SD 57702		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 322	Continued From page 4 This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on record review, interview, and policy review, the provider failed to ensure a physician's order had been received prior to the discharge for one of one sampled resident (18) sent home with medications. Findings include: 1. Review of resident 18's closed medical record revealed: *She had been discharged to her home on 12/2/15. *Medications had been sent home with her at discharge. *There was no physician's order for her medications to have been sent home with her.	S 322	S 322, continued Director of nursing or designee will complete 2 random audits weekly x4 then monthly x2 to ensure the protocol is being followed for residents who are discharged with medications. Results of audits will be brought to the monthly QAPI meeting for further review and recommendations. by the DON or her designee. CHV/SDDOH/EL	03/09/16
	Interview on 2/10/16 at 9:45 a.m. with the director of nursing confirmed there was no physician's order for resident 18's medications to have been sent home with her. Review of the provider's 1/28/16 Discharge/Transfer of the Resident policy revealed if medications were to have been sent home with a resident a physician's order was to have been obtained.			



*CHV/SDDOH/EL