

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CLARK	STREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH AVENUE NW CLARK, SD 57225
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F 000	<p><i>Addendums noted with an asterisk per 3/17/14 telephone to facility administrator. CS/SDOHL/ME</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/10/14 through 2/12/14. Golden LivingCenter - Clark was found not in compliance with the following requirements: F241, F279, and F441.</p>	F 000		
F 241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and policy review, the provider failed to ensure: *Six of eight feeding assisted residents (12, 13, 14, 15, 16, and 17) were served their food at the same time as their tablemates during two of two meal observations. *One of eight feeding assisted residents (12) was seated in the dining room in a manner that promoted visual stimulation. Findings include:</p> <p>1a. Observation on 2/10/14 from 5:55 p.m. through 6:30 p.m. of the evening meal service revealed: *Residents 12, 13, 14, and 15 sat at the same table in the dining room. *At 6:00 p.m. residents 12 and 14 were being assisted with their meals by certified nursing</p>	F 241	<p>Survey Disclaimer Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Margaret Shuman* TITLE: *Executive Director* (X6) DATE: *3/10/2014*

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2014
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OMB NO. 0938-0391

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F 241	<p>Continued From page 1 assistant (CNA) E. *Resident 13 had been sitting at the table while they were being assisted. *Her food was not served until 6:15 p.m. *CNA F sat down at that time to assist resident 13. *At 5:55 p.m. resident 15 had been sitting in the recliner in the living room next to the dining room, in a loud voice he asked to get up from his chair. *Registered nurse H told him they would get him some supper. *At 6:15 p.m. resident 15 was still in the recliner and again asked to get up. *The administrator had gotten his clothing protector, silverware, and drinks from the table and brought them into the living room. *She had gotten his food and assisted him with his meal in the living room.</p> <p>b. Observation on 2/11/14 from 12:00 noon through 12:25 p.m. of the meal service revealed: *Residents 16 and 17 had been sitting at a table with two randomly observed residents. *At 12:00 noon the two randomly observed residents were being assisted with their meal by CNA C. *At 12:05 p.m. residents 13 and 15 were served their food. *Residents 16 and 17 were not served their meal until 12:15 p.m. *Residents 12 and 14 were at the same table but had not been served their food until 12:15 p.m. *CNA D sat down at that time to assist them with their meals.</p> <p>c. Interview on 2/11/14 at 12:25 p.m. with the director of nursing (DON) regarding the meal serving times revealed residents at the same tables should have been served their food at the</p>	F 241	<p>F241 1. On February 13, 2014 staff were educated verbally regarding the need for assisted residents (including 12, 13, 14, 15, 16 and 17) to be served their meal at the same time as their tablemates. Staff were also educated verbally regarding the need for assisted residents to be positioned at the table in a manner that provides visual stimulation. On February 13, 2014 resident 12 was relocated at the dining table in a manner that provides visual stimulation..</p> <p>2. Directed In-service training regarding assisted dining and dignity for dependent residents for all staff was held March 6, 2014 by the Administrator.</p>		

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F 241	Continued From page 2 same time. 2. Observation on 2/10/14 at 6:00 p.m. and on 2/11/14 at 12:05 p.m. of resident 12 revealed he had been placed at the table in the dining room and was facing a refrigerator and a closed door. Observation on 2/11/14 at 12:10 p.m. of resident 12 revealed: *A CNA had stood in front of him, opened up the cabinet next to him, and took out a clothing protector. *The door opened right in front of him and blocked his view. *The CNA closed the cabinet and walked away. Interview on 2/11/14 at 12:25 p.m. with the DON regarding resident 12 revealed: *He depended on staff to move his wheelchair and feed him. *He had been at the same table for meals for a long time. *There were no specific reasons why he was placed in that location at the table. *They had not considered rearranging the tables, so he could have had a better view. Review of the provider's October 2009 Residents' Rights Dignity policy revealed independence and dignity in dining should have been promoted. Review of the provider's May 2013 Notices handbook provided to residents at admission revealed residents had the right to be treated with dignity and respect in full recognition of their individuality.	F 241	3. Administrator or designee will perform random audit of meals to ensure assisted residents are served their meal at the same time as their tablemates and seating in the dining room is provided in a manner that promotes visual stimulation. Audits will be completed weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented to the monthly Quality Assurance and Performance Improvement (QAPI) Committee by the Administrator for review and recommendations.	4-1-2014	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279			

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F 279	<p>Continued From page 3</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>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.</p> <p>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).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to accurately revise the care plan regarding advance directives (written instructions that state how health care decisions were to have been made if a resident was unable to act or respond) for one of one sampled resident (8). Findings include:</p> <p>1. Review of resident 8's complete medical record revealed: *He had been admitted on 10/29/13. *On 10/29/13 he had signed a Consent to Withhold CPR (Cardiopulmonary Resuscitation).</p>	F 279	<p>1. Resident 8's care plan was updated 2/14/14 to match the physician order and Consent to Withhold CPR form. An audit of all residents medical record was completed on 2/28/14 to ensure that the resuscitation orders and the plan of care match.</p> <p>2. The Interdisciplinary Care Plan Team will be educated regarding care plan policy by the Director of Nursing by March 12, 2014.</p> <p>3. Director of Nursing or designee will audit 5 resident medical records to ensure care plan and resuscitation orders match. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented to the monthly QAPI committee by the Director of Nursing for review and recommendations.</p>	4-1-2014

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F 279	<p>Continued From page 4</p> <p>No CPR means that if he had suffered a cardiac (heart) or respiratory (lungs and breathing) arrest (the heart suddenly stops beating or breathing stops) no efforts were to have been made to resuscitate (revive) him. *A physician's order on 10/29/13 for "Do not Administer CPR."</p> <p>Review of resident 8's revised 11/14/13 care plan revealed: *He had an advance directive for full code (all life-saving measures were to have been taken to treat during and after respiratory or cardiac arrest). *His wishes were to have been honored. *CPR was to have been performed as ordered.</p> <p>Interview on 2/11/14 at 9:15 a.m. with registered nurse (RN) A and RN B regarding resident 8's advance directives revealed they would have both checked the physician's order to determine if he had been a full code or not.</p> <p>Interview on 2/12/14 at 12:40 p.m. with the director of nursing regarding resident 8 and his advance directives revealed: *She confirmed he had a physician's order for no CPR. *She confirmed the resident had signed a consent form, and his preference had been for no CPR. *The current care plan had not matched the physician's order and the resident's preferences. *The care plan had not been accurately revised and updated. *The status of a full code or not was to have been reviewed quarterly.</p> <p>Review of the provider's May 2001 Care Plan</p>	F 279			

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F 279	Continued From page 5 policy revealed: *The interdisciplinary care plan was to have been reviewed, revised, and updated quarterly and more frequently if needed by a change in the resident's condition. *The RN or the licensed practical nurse had the responsibility for completing the care plan.	F 279		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		

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F 441	Continued From page 6 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, testing, interview, and policy review, the provider failed to ensure: *Hot water temperatures of 160 degrees Fahrenheit (F) had been maintained in one of one washing machine that did not have chemicals added to sanitize mops and cleaning rags. *A disinfectant had been used on the floors in shared resident rooms and shared resident bathrooms in three of three halls (East, West, and South). Findings include: 1. Interview on 2/11/14 at 9:00 a.m. with laundry assistant I revealed: *The white washing machine was not hooked up to the chemicals used to sanitize the laundry. *She washed mop heads and blue and pink microfiber cloths in the machine. *The microfiber cloths were used by the housekeeping staff. *She had not added bleach or any chemicals to the white washing machine. *She was not sure what the temperature of the water had been in the machine. *There was no way to check the temperature on the machine.	F 441	1. Laundry personnel have been verbally instructed to add bleach manually to the white washing machine. Immediately following survey, housekeeping personnel were instructed verbally to disinfect resident rooms and bathrooms once per week <i>or more often as needed.</i> <i>CS/SDDDH/JMF</i> 2. The white washing machine has been connected to the automatic disinfectant dispensing unit on March 4, 2014. Directed In-Service training was completed on March 6, 2014 to staff regarding infection control and prevention by the Administrator. 3. Administrator or designee will randomly audit floor cleaning procedures of 5 rooms to ensure disinfectant is being used appropriately. Administrator or designee will randomly audit the wash cycle of the white washing machine to ensure that bleach is being added to the cycle. Audits will be performed weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented to the monthly QAPI committee meeting by the Administrator for review and recommendation.	4/1/2014

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F 441	<p>Continued From page 7</p> <p>Interview on 2/11/14 at 10:55 a.m. with the maintenance supervisor revealed he had not tested the washing machine water temperatures. He had been testing the kitchen sink water temperatures. Since they ran on the same water lines he thought that had been okay. The kitchen and laundry rooms were not next to each other.</p> <p>Interview on 2/11/14 at 2:15 p.m. with the laundry and housekeeping supervisor revealed: *The pink microfiber cloths were used to clean the residents' bathrooms. *The blue microfiber cloths were used to dust the residents' rooms. *She had been instructed by her supervisor not to add bleach when they washed the microfiber cloths.</p> <p>Observation, testing, and interview on 2/12/14 at 1:25 p.m. with laundry and housekeeping assistant G revealed: *She had washed mop heads today in the white washing machine on the warm cycle. *After filling the washing machine with a small load on the hot cycle the water temperature had tested at 127 degrees F.</p> <p>Observation, testing, and interview on 2/12/14 at 1:35 p.m. with the maintenance supervisor revealed: *The water temperature had read 133 degrees F on both his thermometer and this surveyor's thermometer. *After filling a large load on the hot cycle without bleach, the water temperature should have been at least 160 degrees F.</p> <p>Review of the provider's 1/11/13 Microfiber Mop Head and Cloth Laundering policy revealed wash</p>	F 441		

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F 441	<p>Continued From page 8</p> <p>cycle water should have been between 140 degrees F and 160 degrees F. Those temperatures had not reflected the correct water temperatures needed for a hot water washing.</p> <p>2. Interview on 2/11/14 at 2:15 p.m. with the laundry and housekeeping supervisor revealed: *They used a neutralizer instead of a disinfectant on all the floors in residents' rooms and residents' bathrooms. *Residents shared rooms and bathrooms in all three halls. *They had used a disinfectant on the floors, but when they switched cleaning companies they had been instructed to use a neutralizer. *They would use disinfectant on the floor if they were notified of a resident having an accident that involved bodily fluids. *She did not have an instruction sheet for the neutralizer.</p> <p>Review of the provider's undated Cleaning the Patient Restroom policy revealed "Prepare your mop bucket solution by filling the bucket at least half full of warm water, and then adding disinfectant cleaner to the water."</p>	F 441			

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/11/14. Golden LivingCenter-Clark was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency at K074 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 074 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3	K 074		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Margaret Shum</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3/10/2014</i>
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K 074	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to verify the required flame resistant qualities of draperies and curtains in two of three common areas (dining room and activities area). Findings include:</p> <p>1. Observation at 1:30 p.m. on 2/11/14 of draperies and curtains in the dining room and activities area revealed no factory installed tags stating the items were flame resistant in accordance with National Fire Protection Association (NFPA) 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. Interview with the maintenance supervisor at 3:30 p.m. on 2/11/14 revealed the draperies and curtains had not been treated with an approved fire retardant material by the provider since 2011 when he began employment at the facility.</p> <p>The deficiency affected a single component of the building's required criteria regarding furnishings, bedding, and decorations.</p> <p>Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1</p>	K 074	<p>K074</p> <p>1. Verification of flame resistance of the draperies in the dining/activity area was emailed to the Department of Health on February 14, 2014.</p> <p>2. Maintenance director conducted a review of all draperies in the facility to ensure verification of flame resistant is documented.</p> <p>3. Maintenance or designee will conduct random audits of draperies on 5 windows to ensure verification of flame resistant is documented. Audits will be conducted weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented to the monthly QAPI committee by the maintenance director for review and recommendations.</p>	4-1-2014
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FORM APPROVED

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CLARK	STREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH AVE NW CLARK, SD 57225
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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
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S 000	Initial Comments Surveyor: 32331 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/10/14 through 2/12/14. Golden LivingCenter - Clark was found not in compliance with the following requirements: S166.	S 000		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must 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 in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;	S 166		

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

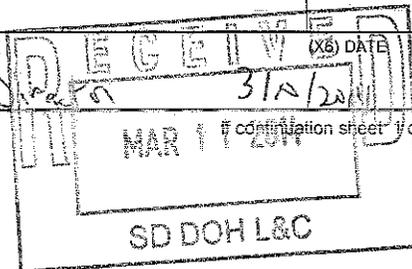
Margaret Durbin

TITLE

Executive Director

(X6) DATE

3/12/2014



SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 166	<p>Continued From Page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Rule is not met as evidenced by: Surveyor: 32335 Based on observation and interview, the provider failed to ensure shatterproof light bulbs had been used in lamps that were over the beds in two of four randomly observed residents' rooms (11 and 12) down the south hall. Findings include:</p> <p>1. Observation on 2/11/14 at 3:45 p.m. revealed: *In room 11 there had been a three light bulb pole lamp over the resident's bed. *The lamp had three light bulbs that were not shatterproof. *In room 12 there had been a lamp over the resident's bed that had one light bulb that was not shatterproof.</p> <p>Interview on 2/11/14 at the above time with the maintenance supervisor revealed the bulbs in both of those lamps should have been shatterproof.</p>	S 166	<p>S166</p> <p>1. Shatterproof light bulbs were installed in lamps that are over the beds in resident's room 11 and 12. On February 12, 2014 an audit was completed of all residents rooms to ensure that a shatterproof light bulb was being used in lamps over resident's beds.</p> <p>2. Staff was educated by the Administrator on February 13, 2014 of the need for shatterproof light bulbs in lamps that are over the bed. Staff will be educated by 3/12/14 regarding the need to use shatterproof light bulbs in lamps that are used over a resident's bed.</p> <p>3. Maintenance Director or designee will conduct random audits of 5 resident rooms to ensure shatterproof light bulbs are in place in lamps over the resident's beds. Audits will be completed weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented to the monthly QAPI committee by the Maintenance Director for review and recommendations</p> <p style="text-align: right;">4-1-2014</p>	