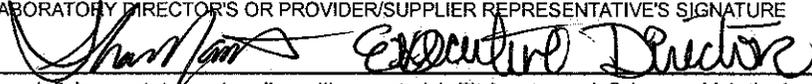


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

ORIGINAL

PRINTED: 08/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MOBRIDGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 FOURTH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	(X5) COMPLETION DATE
F 000	<p><i>Addendum noted with an asterisk per 9/11/14 telephone to facility administrator JASBOWHME</i></p> <p>Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/4/14 through 8/6/14. Golden LivingCenter - Mobridge was found not in compliance with the following requirement(s): F281 and F441.</p> <p>F 281 SS=E 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, interview, manufacturer's review, and policy review, the provider failed to ensure: *NovoLog (rapid-acting insulin) had been given no sooner than fifteen minutes before they received a meal for three of four residents (4, 23, 24). *A physician's order had been followed for 1 of 1 resident (24) regarding insulin administration and food intake. *Clarification of a physician's order for 1 of 19 sampled residents (10) had been completed. *Appropriate personnel had performed a wound treatment on a stage II pressure ulcer for 1 of 3 sampled residents (11) with a pressure ulcer. Findings include:  1. Observation on 8/5/14 at 11:08 a.m. revealed licensed practical nurse (LPN) A had administered NovoLog insulin twelve units</p>	F 000		
		F 281	<p>F 281</p> <p>1. Residents 4, 23, 24 will be receive a snack when Novolog is administered. Resident 10 medication record was corrected. Resident 11 will have treatment completed by a licensed nurse. 2. All resident are at risk. Residents who receive fast acting insulin will have a potential to develop hypoglycemia and will receive a snack prior to Novolog administration.</p>	9/22/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
 8/28/14

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.

SEP 02 2014

SD DOH L&C

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F 281	<p>Continued From page 1</p> <p>subcutaneously (SQ) to resident 4. Resident 4 did not receive his meal until 12:25 p.m. That was one hour and seventeen minutes after he had received his insulin.</p> <p>2. Observation on 8/5/14 at 11:19 a.m. revealed LPN A had administered NovoLog insulin fifteen units SQ to resident 23. Resident 23 did not receive her meal until 12:12 P.M. That was fifty-three minutes after she had received her insulin.</p> <p>3. Observation on 8/5/14 at 11:25 a.m. revealed registered nurse (RN) B had administered NovoLog insulin eight units SQ to resident 24. Resident 24 did not receive her meal until 12:10 p.m. That was forty-five minutes after she had received her insulin. RN B had not primed the insulin pen prior to administering that insulin. Resident 24 also had a 8/4/14 physician's order to hold the insulin if she refused the meal. She did start to eat her meal when it was served at 12:10 p.m.</p> <p>4. Interview on 8/6/14 at 10:25 a.m. with the director of nursing confirmed the above insulin had not been administered within fifteen minutes of the residents eating their meals.</p> <p>Interview on 8/6/14 at 8:00 a.m. with registered nurse (RN) B revealed: *She was a travel RN within the company. *She was not aware resident 24 had a specific physician's order to hold her insulin if she had not eaten. *She was not aware the NovoLog insulin pen was to have been primed with two units before the administration of a resident's insulin dose.</p>	F 281	<p>3. DNS have reviewed the policy on medication administration, including the rights (right resident, right documentation, right medication, right dosage/form, right time, right route, and right effect). Finding from this citation will be shared at an in-service will occur no later than August 28, 2014.</p> <p>4. All licensed nurses will be in-serviced on rapid acting insulin and the need to be administered within 15 minutes of food intake as well as priming the insulin pen with 2 units of insulin prior to administration. A snack will be provided prior to insulin administration. An insulin guide will be available at each nursing cart. Audits will be completed weekly for four weeks and then monthly for 3 months. The results of audits will be reviewed monthly for further review and recommendations and/or continuation/discontinuation of audits. All nurses and UAP's will be in-serviced on treatments for pressure ulcers not being delegated to UAP's. *see page 3</p> <p>5. Corrective Action will be completed by September 22, 2014.</p>	

\* by the DNS or designee. JASDDH/MF

\* of insulin administration and snack administration JASDDH/MF

\* taken to QAPI by the DNS or designee and JASDDH/MF

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F 281	<p>Continued From page 2</p> <p>Review of the provider's meal service schedule revealed:</p> <ul style="list-style-type: none"> <li>*Lunch was scheduled to be served in the Alzheimer's care unit (ACU) at 11:45 a.m. and the main dining room at 12:00 noon.</li> <li>*Supper was scheduled to be served in the ACU at 5:50 p.m. and the main dining room at 6:00 p.m.</li> <li>*Residents 4 and 23 ate their meals in the main dining room, and resident 24 ate her meals in the ACU dining room.</li> </ul> <p>Review of the provider's February 2009 Insulin Tip Sheet revealed:</p> <ul style="list-style-type: none"> <li>*NovoLog insulin had an onset of action of fifteen minutes or less after administration.</li> <li>*NovoLog insulin had a peak effect of one-half to one hour after administration.</li> <li>*Administration should have occurred within fifteen minutes of mealtime due to rapid action.</li> <li>*May be ordered to be administered after the meal due to rapid onset of action.</li> <li>*Insulin dependent individuals greatest risk of hypoglycemia (low blood glucose) was during the time of peak insulin effect.</li> <li>*Estimates suggested one to two units of NovoLog insulin would lower the blood glucose by twenty-five to fifty points.</li> </ul> <p>Review of the provider's 2007 Medication Administration policy revealed medications were to be administered in accordance with the written orders of the prescriber. There was no information regarding the administration of insulin or the timing of the administration of insulin.</p> <p>Surveyor: 23059 5. Review of resident 10's August 2014 medication administration record (MAR) revealed</p>	F 281	<p><i>*Audits performed by the DNS or designee will be done monthly times 3 for 3 months. The results of the audits will be taken by the DNS or designee and reviewed monthly for further review and recommendations and/or continuation/discontinuation of audits.</i></p> <p><i>JAKDDH/MF</i></p>		

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F 281	<p>Continued From page 3</p> <p>an entry for hydralazine (medication to control blood pressure) 75 milligrams (mg) two times daily.</p> <p>Review of her signed 7/2/14 physician's orders revealed an order for hydralazine 25 mg to have been given twice daily.</p> <p>Interview on 8/5/14 at 2:10 p.m. with the DON revealed two nurses reviewed all orders at the end of each month. They were to have checked the medication orders with the medications listed on the MAR to ensure accuracy. She confirmed the MAR did not match the physician's order.</p> <p>Interview on 8/5/14 at 2:15 p.m. with the DON revealed she had visited with the nurse who had checked resident 10's orders. She stated the nurse had noted the discrepancy but had not clarified the order with the physician. She stated she had planned to talk with the physician at his next visit. She confirmed that order should have been clarified when it did not match the entry on the MAR.</p> <p>Review of the provider's December 2012 Medication Administration policy revealed medications were to have been given in accordance with the written orders of the physician. If necessary the nurse should have contacted the prescriber for clarification.</p> <p>Surveyor: 32333 5. Review of resident 11's 7/28/14 progress notes revealed: *He had an open area to his right inner buttocks measuring 1.8 by 1.4 by 1 (no unit of</p>	F 281		

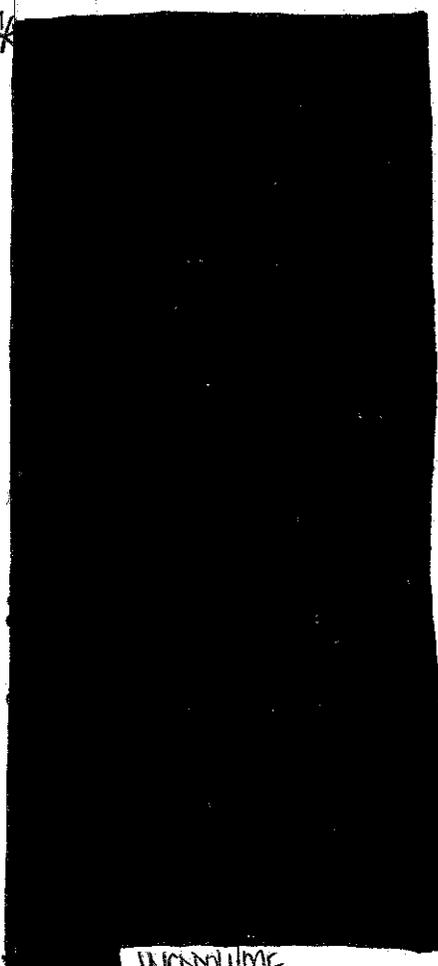
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F 281	<p>Continued From page 4 measurement had been noted).</p> <p>*The surrounding tissue was reddened but blanched.</p> <p>*The assessment was documented as a pressure ulcer (skin breakdown), and the physician had been notified of the pressure ulcer.</p> <p>Review of resident 11's care plan updated on 7/28/14 revealed he had a stage II pressure ulcer on his right inner buttock.</p> <p>Review of resident 11's 7/28/14 physician's orders revealed barrier cream to his buttock three times a day.</p> <p>Review of resident 11's July and August 2014 treatment administration record revealed: *Protective skin barrier three times a day for the open area on right buttock until healed. *His treatment had been documented as applied by several unlicensed assistive personnel (UAP) four times.</p> <p>Interview on 8/7/14 at 2:00 p.m. with the DON revealed treatment of a stage II pressure ulcer could be performed by a UAP as long as there was not a dressing to the site.</p> <p>Review of the provider's 7/12/13 Medication Aide Responsibilities revealed: *No mention as to whether or not a UAP could provide treatment to a stage II pressure ulcer. *Medication aides cannot "Do any dressing changes!"</p> <p>Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Ed., St. Louis, MO., 2005, p. 1519, revealed "Treatment of pressure ulcers should not be delegated to assistive</p>	F 281		

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F 281	Continued From page 5 personnel."	F 281			
F 441 SS=E	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 Pr (1) in (2) sh (3) ac  (b) (1) de pr is (2) co fr di (3) hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441			

*I duplicated same copy on pages 6 of 12 and 7 of 12.  
Sincerely,  
John Mark 8/27/14*

*JMSDDHMF*

*JMSDDHMF*

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F 441	Continued From page 6  This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, manufacturer's recommendations review, and policy review, the provider failed to ensure: *There had been an appropriate procedure for the disinfection of one of two whirlpool tub rooms in one of two wings (south) on the main unit. *Chemicals had been stored away from resident use items in the shower rooms on three of four wings (north, south, and the acute Alzheimers care unit (AACU). *Three randomly observed multiple resident use men's electric razors had been cleaned after each use. *One of one utility room in the Alzheimer's care unit (ACU) had not stored resident use items with chemicals underneath the sink. *Proper sanitizing of the glucometer had been completed by one of one unlicensed assistive personnel (UAP) D for two of two observed residents (28 and 29). Findings include:  1. Observation and interview on 8/6/14 at 8:40 a.m. with certified nursing assistant (CNA) G while she verbalized how she would disinfect the whirlpool tub on the south hall revealed: *She was the scheduled bath aide for that day. *She was not usually scheduled as a bath aide. *She usually worked in the ACU or AACU. *She had been unsure of the steps to clean the whirlpool tub. *She stated she had not used that tub in over a year.	F 441	F 441  Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.  F 441  1. Corrected instructions for cleaning whirlpool has been updated. Chemicals not stored with residents personal care items. Residents with facial hair will have own razors.		

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F 441	<p>Continued From page 7</p> <p>*A procedure on how to clean the tub was attached to a cabinet next to the tub. *She retrieved the posted procedure and read it. *She stated the disinfectant would not need to be on the tub surfaces for any length of time according to the posted procedure.</p> <p>Review of the undated procedure that had been posted in the south hall whirlpool tub room revealed: *The procedure had not addressed a length of time to allow the disinfectant to be on the tub surfaces. *The procedure stated "Each day after everyone has bathed, the tub should be sanitized according to the above procedure."</p> <p>Review of the Classic disinfectant manufacturer's label revealed directions to allow the product to remain wet on the surface for ten minutes to disinfect.</p> <p>2. Random observations from 8/4/14 through 8/6/14 of the shower rooms on the north and south wings and in the AACU revealed: *The north wing: -Had two shower rooms, one of the shower rooms had a cabinet with a key hanging off the side of it. -That cabinet contained two bottles of A-456ll disinfectant stored with multiple items that included bottles of residents' bodywash/shampoo, and deoderant (photo 1). *The south wing: -Had a locked cabinet with a key hanging from the side of it. -That cabinet had a shelf with a bucket on it. The bucket had been soiled with white colored debris inside it.</p>	F 441	<p>F 441</p> <p>2. All resident who take whirlpools, all residents with facial hair, and personal items co-mingled with chemicals are at risk.</p> <p>3. DNS or designee will provide nursing and UAP an in-service on cleaning/disinfecting procedure for glucometer supply container, whirlpools, and razors and updated instructions for the whirlpool have been posted in whirlpool room for proper cleaning of whirlpool.</p> <p>4. Audits will be completed weekly for four weeks and then monthly for three months <i>*by the DNS or designee. JALSDDH/MF</i> The results of audits will be reviewed at the monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits. <i>*reported by the DNS or designee and be JALSDDH/MF</i></p> <p>5. Corrective Action will completed by September 22, 2014.</p> <p><i>* JALSDDH/MF</i></p> <p><i>*of cleaning/disinfecting of glucometer container, whirl pool and razors JALSDDH/MF</i></p>	

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F 441	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>-That bucket contained multiple resident use items including soiled and rusted nail clippers, a mens electric razor containing skin and hair debris, shampoo/body wash, a hairbrush, and a toothbrush (photo 2).</li> <li>-That shelf also had A-456II disinfectant and Fresh Breeze detergent and disinfectant stored on it.</li> <li>*The AACU: <ul style="list-style-type: none"> <li>-Had a locked cabinet with a key hanging from the side of it.</li> <li>-That cabinet had two bottles of A-456II disinfectant stored with resident use items including shampoo/body wash and baby powder.</li> </ul> </li> </ul> <p>3. Random observations from 8/4/14 through 8/6/14 of multiple resident use men's electric razors revealed:</p> <ul style="list-style-type: none"> <li>*A multiple resident use men's electric razor in the south hall shower room.</li> <li>-That razor had contained skin and hair debris in it (photo 3).</li> <li>*Two multiple resident use men's electric razors in the ACU utility room.</li> <li>-Those razors had contained skin and hair debris in them.</li> </ul> <p>Review of the providers revised October 2009 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed "Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions."</p> <p>4. Random observations on 8/5/14 and on 8/6/14 of the utility room in the ACU revealed:</p> <ul style="list-style-type: none"> <li>*The utility room had a sink with a cabinet underneath of it.</li> <li>*Multiple items had been stored underneath of</li> </ul>	F 441		

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F 441	<p>Continued From page 9 the sink. *Those items included multiple cleaning chemicals such as Comet bleach, glass cleaner, and disinfectant sprays, a bucket of resident use items including lotion, hair detangler, and body spray, pillow case with compact discs, cotton balls and other random items (photo 4).</p> <p>5. Interview on 8/6/14 at 2:00 p.m. with the director of nursing and the infection control nurse revealed: *They confirmed the procedure to disinfect the south hall whirlpool tub had been incorrect. *They would have expected the scheduled bath aide to have known the appropriate procedure to disinfect the whirlpool tub. *Resident use items should not have been stored with cleaning chemicals. *Resident use items should have been stored in a sanitary manner. *Men's electric razors should have been cleaned appropriately after each use. *No resident care items should have been stored underneath the sink in the ACU.</p> <p>Surveyor: 26632 6. Observation and interview on 8/5/14 at 5:20 p.m. and at 5:30 p.m. revealed UAP D: *Had a plastic weave basket that contained lancets, individual alcohol pads, and individual glucometer strips. The glucometer had been placed on top of the lancets. *Took that basket into resident 28's room and placed the basket on a bedside table. *Performed the blood glucose test for resident 28. *Placed the glucometer back into the basket and carried it to the medication cart. *Sanitized the glucometer with a bleach sanitizing wipe and placed the glucometer back on top of</p>	F 441			

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

PRINTED: 08/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MOBRIDGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 FOURTH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601</b>		
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F 441	<p>Continued From page 10</p> <p>the lancets. She did not sanitize the bottom of the glucometer supply basket.</p> <p>*At 5:30 p.m. UAP D again retrieved the glucometer supply basket from the medication cart, located resident 29 in the hall, and pushed him in his wheelchair to his room.</p> <p>*Set the glucometer supply basket on his bedside table and performed the blood glucose test.</p> <p>*Wiped the glucometer off with an alcohol pad and placed it back on top of the lancets.</p> <p>*Carried the glucometer supply basket back to the medication cart.</p> <p>*Stated "If there were a lot of blood sugar tests it was O.K. to just wipe them off with an alcohol pad between residents."</p> <p>Interview on 8/6/14 at 10:25 a.m. with the DON revealed:</p> <p>*The manufacturer's recommendations for cleaning the glucometer included the use of seventy percent alcohol.</p> <p>*She was not aware that alcohol did not sanitize the glucometer.</p> <p>Review of the provider's 2007 Blood Glucose Monitor Decontamination policy revealed:</p> <p>*The blood glucose monitor would be cleaned and disinfected with wipes following the use on each resident when monitors were shared.</p> <p>*The nurse would obtain the blood glucose monitor along with the wipes and place the monitor on a clean surface.</p> <p>*After performing the glucose testing the nurse wearing gloves would use a Dispatch wipe to clean all external parts of the monitor.</p> <p>*A second wipe would be used to disinfect the blood glucose monitor.</p> <p>*The disinfected monitor would be placed on another clean surface.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MOBRIDGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 FOURTH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601</b>		
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F 441	Continued From page 11 *The monitor would be placed in the medication cart or other clean storage area until needed.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/05/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MOBRIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 FOURTH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601</b>
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K 000	<p><i>Addendums noted with an asterisk per ability telephone to facility administrator LF/SDDOH/MF</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/5/14. Golden LivingCenter-Mobridge 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 K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.</p>	
K 038 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure exits were readily accessible at all times. One of eleven marked exit doors (main entrance) was equipped with a magnetic lock and was not provided with the proper delayed egress signage. Findings include:</p> <p>1. Observation at 12:45 p.m. on 8/5/14 revealed a marked exit at the main entrance. Further observation revealed that exit was equipped with a magnetic locking device. Interview with the</p>	K 038	<p>1. The marked exit magnetic delayed egress door has proper signage indicating "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS." *</p> <p>2. All residents with wander guards are affected.</p> <p><i>This was completed by the Maintenance Supervisor. The egress door will be monitored by the Maintenance Supervisor and department head designate as their role during Manager on duty during the weekends. LF/SDDOH/MF</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>8/28/14</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435052</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/05/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MOBRIDGE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 FOURTH AVENUE EAST POST OFFICE BOX 937 MOBRIDGE, SD 57601</b>	
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K 038	Continued From page 1 maintenance supervisor at the time of observation revealed that magnetic lock was activated at 9:00 p.m. for security purposes. That magnetic lock also activated upon approach of a resident assessed as having the potential to elope and equipped with a wander management pendent. Further interview revealed that door was also equipped with a delayed egress feature that would provide egress upon activation of that delayed egress feature during the times that magnetic lock was activated. Delayed egress signage was not provided on the door indicating "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS." This signage is required on all marked exits utilizing the delayed egress feature. Further interview revealed the maintenance supervisor was aware of that requirement and indicated that doors delayed egress signage had been missed at the time the magnetic locks were installed.	K 038	 LFJSDOH/ME *3. The delayed egress signage was placed on the door indicating "PUSH UNTIL ALARM SOUNDS, DOOR CAN BE OPENED IN 15 SECONDS" by our Maintenance Supervisor on August 5th 2014. The egress door alarm will be tested by the Maintenance Supervisor or department head designate daily for the next three months. The record of these alarm tests will be placed in the preventative maintenance book located in the nurse's chart room. LFJSDOH/ME *4. The interdisciplinary will review the record results at the ADPI meeting monthly for the next three months as an action plan item. LFJSDOH/ME	8/07/2014

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10656</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - MOBRIDGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1100 4TH AVENUE E MOBRIDGE, SD 57601</b>
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S 000	Initial Comments  Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/4/14 through 8/6/14. Golden LivingCenter - Mobridge was found not in compliance with the following requirement: S236.	S 000	<i>Addendums noted within asterisk per 9/14/14 telephone to facility administrator. JAS/DDOCH/MF</i> Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS  Tuberculin screening requirements for healthcare workers or residents are as follows:  (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 23059 Based on record review, interview, and policy review, the provider failed to ensure two of five sampled employees (E and F) had a two-step	S 236	<i>S236 236</i> <i>*All JAS/DDOCH/MF</i> 1. <input type="checkbox"/> new healthcare worker or resident will be provided with a timely two step Mantoux skin test within 14 days.  2. All new healthcare workers or residents are at risk.  <i>*Employee E has received the 2 step TB testing. JAS/DDOCH/MF</i> <i>*Employee F has since been terminated. JAS/DDOCH/MF</i>	9/22/2014

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

TITLE

*Executive Director*

STATE FORM

8699

TR7J11

	(X6) DATE
	8/28/14
	If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10656</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/06/2014</b>
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S 236	<p>Continued From page 1</p> <p>tuberculin (TB) screening done within fourteen days of their employment. Findings include:</p> <p>1. Review of registered nurse (RN) E's employee file revealed she had been hired on 4/15/14. She had the first part of her two-step TB skin test given on 4/15/14 and read on 4/17/14. The second step had not been administered until 5/22/14 and read on 5/23/14. An additional TB screening had been done on 6/1/14 and read on 6/4/14.</p> <p>2. Review of dietary aide F's employee file revealed she had been hired on 5/22/14 but had not started employment until 5/27/14. Her initial TB screening test had been done on 6/9/14 and read on 6/11/14. The second step had been done on 6/18/14 and read on 6/20/14.</p> <p>3. Interview on 8/6/14 at 10:50 a.m. with the director of clinical education (DCE) revealed RN E had not come to her for the second-step TB screening. The DCE stated she then started the process again for the two-step, thirty-seven days after RN E's employment date. She confirmed the second step for RN E should have been done sooner. She also confirmed the two-step process for employee F had not been completed within fourteen days after she began employment.</p> <p>Review of the provider's undated Tuberculin Screening Requirements policy revealed every employee was to have received the two-step method of TB testing within fourteen days of employment.</p>	S 236	<p>S 236</p> <p>3. DNS or designee will complete on all new healthcare workers or residents the two step Mantoux skin tests within 14 days of admission or start of employment. The Director of Clinical Education was made aware of the regulations during the survey. <i>by the DNS or designee JAK/ODD/HMF</i></p> <p>4. Audits will be completed weekly for four weeks and then monthly for three months. The results of audits will be reviewed at the monthly meeting for further review and recommendations and/or continuation/discontinuation of audits. <i>JAK/ODD/HMF</i></p> <p>5. Corrective Action will completed by September 22, 2014.</p> <p><i>taken to QAPI by the DNS or designee to be JAK/ODD/HMF</i></p>	
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