

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

ORIGINAL

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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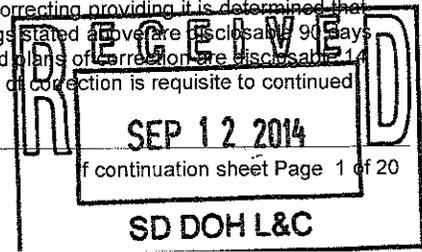
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469
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F 000	<p><i>Addendums noted with an asterisk per 9/10/14 telephone to facility interim administrator. JTS/DOH/ME</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 8/19/14 through 8/21/14. Golden LivingCenter - Redfield was found not in compliance with the following requirements: F323 and F441.</p>	F 000	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.	
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review, interview, policy review, and manufacturer's product information and instruction review, the provider failed to maintain a safe environment with appropriate supervision and monitoring for two of five sampled residents (5 and 14) that had fallen resulting in major injuries. Findings include:</p> <p>1. Review of resident 14's complete medical record revealed: *A diagnosis of Alzheimer's disease (confused mental thinking). *He had been a resident in the advanced Alzheimer's care unit (AACU). *A history of wandering and falls.</p>	F 323	<p>* Resident 14 no longer resides in the facility and unable to change past events. JTS/DOH/ME</p> <p>As of 5/17/14 at 1530, AACU exit door to courtyard was not propped open; exit door was securely locked. AACU staff on duty 5/17/2014 and 5/18/14 were instructed that AACU exit door was not to be propped open, but remain securely locked.</p> <p>All residents at risk for falls due to physical, behavioral or cognitive deficits, have the potential to be affected. On 5/20/14, all facility staff were educated that no outside exit doors are to be propped open, but remain securely locked.</p> <p>May 2014, prevention of falls education was provided to all staff through written materials via IDNS. On June 5, 2014 falls prevention education was presented to ACU/AACU staff via in-</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra McNaugh</i>	TITLE <i>Interim NHA</i>	(X6) DATE <i>9/10/2014</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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F 323	<p>Continued From page 1</p> <p>*He had been assessed to be at risk for falls. *He had been assessed to be at risk for elopement (leaving the facility).</p> <p>Review of resident 14's nursing progress notes revealed: *On 5/17/14 at 3:06 p.m. "Was found outside without any other people. Found on ground." Vital signs taken. "Neuro check completed & [and] will not bear weight or stand. States his left hip hurts." *On 5/17/14 at 3:30 p.m. "Wife was in AACU when resident was found outside on ground. Contacted Dr. _____ at CMH [Community Memorial Hospital] & received order to transport to ER [emergency room] via ambulance." *On 5/17/14 at 6:23 p.m. "Talked to Dr. _____ from CMH ER, resident has a minimally displace fracture of the left hip neck. Family does not want surgery. Will be admitted to hospital for pain control. Family with resident."</p> <p>Review of resident 14's 5/17/14, 5-Working Day Investigation report revealed "Through observation, (independently ambulatory) resident had been ambulating in outside courtyard with wife and another facility resident. This resident, along with wife and other facility resident came back into facility through an opened door from AACU to courtyard. (CNA [certified nursing assistant] reported that she opened AACU door to courtyard to allow those using courtyard free access from facility into courtyard and back into facility.) Wife and other resident sat down at an AACU dining room table to visit. Within moments, CNA staff near dining room observed this resident to not be in accompaniment of wife and other resident. At this time, CNA who was in another resident's room observed this resident through window to be ambulating in courtyard and began</p>	F 323	<p>service by IDNS. On July 17, 2014 a falls prevention education was presented to all staff by Golden Living Clinical Consultant.</p> <p>A directed all staff in-service training regarding the provision of care that meets the residents' physical, mental and psychosocial well being, including the necessity to maintain an environment that promotes resident safety will be provided by 9/19/14.</p> <p>Maintenance personnel or designee will audit exits to ensure they are properly secured weekly x 4 then monthly x 1. Results of these audits will be presented by the Maintenance personnel to the monthly QAPI committee for review and recommendation. Executive Director (ED) or designee will perform random audits of the AACU exit door to ensure that it is properly secured. Audits will be completed weekly x 4, then monthly x 1. Results of these audits will be presented by the ED to the monthly QAPI committee for review and recommendation</p>	
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F 323	<p>Continued From page 2</p> <p>her way to the courtyard; at this time, RN [registered nurse] in ACU [Alzheimer's Care Unit] received a report from a resident's family member visiting in the facility, who had been looking out of another window, that there was a gentleman on the ground in the courtyard. This family member reported to the RN that it appeared that this gentleman attempted to sit in the swing (located in the courtyard) and missed the swing, falling to the ground. RN responded immediately to courtyard finding the CNA (who had seen resident ambulating in courtyard through a resident room window) had reached the courtyard and the resident who was laying on ground."</p> <p>Review of resident 14's 3/24/14 Minimum Data Set assessment revealed: *For transfers he had been assessed to require extensive physical assistance, staff to provide weight bearing support with two plus person assistance. *For ambulation he had been assessed to require supervision with one person for physical assistance.</p> <p>Review of the South Dakota Department of Health 11/7/13 recertification survey revealed the provider had been cited under F323 for the unsupervised access to the courtyard with access doors from the ACU and AACU. It also addressed the ACU door was being propped open. Refer to tag F323, finding 1, from the 11/7/13 survey.</p> <p>Review of the providers 12/27/13 plan of correction from that 11/7/13 survey revealed: *A directed in-service training would be provided to staff by 12/5/13 regarding provision of care that meets the resident's physical, mental, and psychosocial well being including the necessity to</p>	F 323 <i>*#15 JTS/DJH/ME</i> <i>*#15 JTS/DJH/ME</i> <i>*#15 JTS/DJH/ME</i>	<p>On 7/22/14, seat belt alarm battery for resident [redacted] was changed. Beginning 7/30/14, monitoring of seat belt alarm for resident [redacted] for proper functioning was done by nursing staff every 2 hours while resident in wheelchair and logged in electronic medical record; as of 8/7/14, the monitoring of the change of alarm battery every month per manufacturer's recommendation is logged by nursing per resident's medical record. On 7/22/14, all staff were educated regarding the proper monitoring of resident [redacted] seat belt alarm to assure alarm is on and functioning. In early August, 2014, monitoring of resident's alarm added to CNA daily assignment sheet.</p> <p>All residents who have positioning alarms in place have the potential to be affected. All positioning alarms in use in building were assessed for proper functioning by 9/4/14. All positioning alarms in use in building are assessed and logged by nursing via the electronic medical record for proper functioning on daily basis with the changing of alarm batteries done and logged by nursing per the manufacturer's recommendations on 9/4/14.</p>	

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F 323	<p>Continued From page 3</p> <p>maintain an environment that promoted resident safety.</p> <p>*Maintenance personnel or designee would audit exits to ensure they alarmed, locked and unlocked properly weekly for four weeks, then monthly for three months.</p> <p>Interview on 8/20/14 at 10:50 a.m. with the ACU and AACU director revealed: *On the ACU residents were allowed to go outside with family. *On the AACU staff were supposed to go outside with residents. *Doors were never supposed to have been propped open.</p> <p>Interview on 8/20/14 at 1:15 p.m. with the maintenance director revealed the door to the AACU should never have been propped open. That door was supposed to have been locked at all times.</p> <p>Interview on 8/20/14 at 1:50 p.m. with the administrator revealed there had been no policy relative to the door in the AACU leading out to the courtyard. That door was supposed to have been locked at all times. If residents had been assessed to be ambulatory they could be unsupervised in the courtyard. They had not done any specific assessment for safety for residents to go outside. That door should have never been propped open.</p> <p>Interview on 8/20/14 at 2:25 p.m. with the director of nursing revealed the above door should not have been propped open. The best practice would have been for residents to have been supervised. All residents in the AACU should have been supervised when outdoors. There had</p>	F 323	<p>Education to all staff regarding proper use and functioning of patient body alarms will be completed by 9/19/14.</p> <p>Director of Nursing Service (DNS) or designee will audit documentation of alarm function weekly x 4 and monthly x2. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.</p> <p>Lift assessment for resident #3 was updated on 9/8/14 to include resident's preference for intermittent use of Sara Lift leg straps. All residents who are transferred with the use of sit to stand lifts are at risk. Proper use of lifts audits and re-education as needed beginning early May 2014, remain in progress.</p> <p>DNS or designee will randomly audit 3 transfers with sit to stand lifts weekly x 4 weeks; monthly x 2 and report findings to QAPI for further review and recommendations.</p> <p>A directed all staff in-service training regarding the provision of care that meets the residents' physical, mental and psychosocial well being, including the necessity to maintain an environment that promotes resident safety will be provided on 9/19/14 to include</p>	

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F 323	<p>Continued From page 4</p> <p>been no policy regarding the supervision of a residents in the courtyard or propping doors open. If a door was locked the resident should have been accompanied outside.</p> <p>Surveyor: 32331</p> <p>2. Review of resident 5's medical record revealed she:</p> <ul style="list-style-type: none"> *Had been admitted on 3/13/07. *Had diagnoses that included Parkinson's disease (a progressive disorder of the nervous system) and a lack of coordination. *Was at risk for falls with a score of 12 (a total score of 10 or above made the resident at risk). *Had fallen on 7/22/14 on the floor in front of her sink in her room. -She was found on the floor at 2:03 p.m. -That fall had been unwitnessed by staff. -Had been unresponsive for ten minutes after she had been found on the floor. -Had a laceration (break in the skin) to the back of her head, a bruise to her right elbow, and a skin tear to her left forearm. -Had discomfort to left shoulder reported. -Was taken to the emergency room by an ambulance at 2:15 p.m. <p>Review of resident 5's 8/14/14 care plan revealed she:</p> <ul style="list-style-type: none"> *Was at risk for falls related to impaired mobility/balance. *Had a history of falls. *Had impaired safety awareness. *Was to have been checked for wheelchair positioning frequently throughout each shift. *Was encouraged to always call for help when needed. *Was to have left her seat belt on as a reminder 	F 323	<ul style="list-style-type: none"> • accident prevention by not propping exit doors open • monitoring the alarming seat belts for being turned on and properly functioning batteries • providing residents with adequate supervision • properly following manufacturer's use directions for all devices to include the sit-to-stand lifts 	9/19/2014

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F 323	<p>Continued From page 5 that it was for her own safety.</p> <p>Review of resident 5's 7/22/14 initial nursing facility event report required by and reported to the South Dakota Department of Health revealed:</p> <ul style="list-style-type: none"> *She been been found on the floor in the room by the sink. *She had sustained an approximate two centimeter laceration to the back of head that had been bleeding profusely (excessively). *She went to the emergency room by ambulance where she had been evaluated for injuries. *She returned to the facility with no sutures (stiches) or report of further injuries. *She had an alarming seat belt on when up in her wheelchair that she could remove independently. *The alarm had not sounded when she had fallen. *Staff had stated awareness of the need to have punched the alarm 'on' when she had been transferred into the wheelchair. *The alarm light remained a constant blue on the personal alarm when the alarm was on. *Staff had found the blue alarm light had been blinking. *The battery changed the alarm light to a constant blue. *Staff had been educated on the need to have observed the alarm light to ensure the alarm was on when she was in the wheelchair. *Staff were to have reported if the light was blinking as that meant the battery needed to have been changed. <p>Review of resident 5's physician's orders revealed: On 9/20/12 "TABS [a type of personal alarm system] Alarm for safety." *On 1/21/14 "Patient may continue to utilize Velcro seatbelt to improve positioning and safety.</p>	F 323		

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F 323	<p>Continued From page 6 (Note patient is able to remove independently and on command)." *On 8/7/14 "Change battery to seat belt alarm q [every] 30 days every day shift every 30 day(s) for Prevention." *The above order on 8/7/14 was written after the resident had fallen on 7/22/14 and had sustained a major injury.</p> <p>Review of resident 5's treatment administration record revealed: *On 7/30/14 "Check seat belt alarm to ensure it is working properly Q [every] 2 hours while in wheelchair." *The above order on 7/30/14 was written after the resident had fallen on 7/22/14 and had sustained a major injury.</p> <p>Interview on 8/19/14 at 4:00 p.m. and on 8/21/14 at 10:30 a.m. with the director of nursing (DON) regarding resident 5's fall on 7/22/14 revealed: *She had been toileted at 11:00 a.m. *She had fallen at 2:00 p.m. *She had been taken to the emergency room after she had fallen. *Upon her return from the emergency room her personal alarm light had been blinking. *The battery had been changed at that time, it was no longer blinking, and it was a constant blue. *There was a nursing assignment care sheet used for communication to direct care staff regarding each resident's observation and condition changes. -She was currently listed on the care sheet with "Seatbelt alarms at ALL times (blue light must be on, not flashing)." -The DON reported the above had not been on the care sheet prior to her fall; it had been added</p>	F 323			

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F 323	<p>Continued From page 7 after her fall on 7/22/14.</p> <p>*The DON agreed the seatbelt's blue light needed to have been more closely monitored and the battery changed on a regular schedule.</p> <p>-She confirmed the resident's personal alarm light had not been properly working.</p> <p>-She confirmed the alarm had not sounded prior to the resident's fall on 7/22/14 resulting in a major injury.</p> <p>-She confirmed the manufacturer's production information for the seatbelt alarm had not been followed.</p> <p>Review of the undated manufacturer's product sheet information for resident 5's Safe-mate Alarmed Velcro Seatbelt revealed:</p> <p>*"Test the belt for proper operation.</p> <p>*Firmly press the switch to the ON position (blue LED light remains lit).</p> <p>*The alarm should sound as soon as the belt is separated."</p> <p>*The device was not a substitute for proper supervision.</p> <p>*Check fall risk patients frequently.</p> <p>*Change battery monthly.</p> <p>Interview on 8/21/14 at 11:00 a.m. with the administrator revealed the provider had no policy on personal resident alarms.</p> <p>Review of the provider's revised 2013 Falls Management Clinical Guidelines policy revealed at risk residents were identified through a "fall alert" communication system to caregivers.</p> <p>Surveyor: 34030 Preceptor: 18560 B. Based on record review, interview, and</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>manufacturer's guideline review, the provider failed to ensure a sit-to-stand lift (a type of lift used to move a resident) was used in a safe manner for one of one sampled resident (3) who was mentally unable to make an informed decision regarding use of the lift. Findings include:</p> <p>1. Review of resident 3's medical record revealed: *An admission date of 12/4/12. *Diagnoses that included Alzheimer's disease (decreased mental ability) and psychosis (disturbed thinking).</p> <p>Review of resident 3's 6/10/14 quarterly Minimum Data Set (MDS) assessment revealed she: *Had a Brief Interview for Mental Status score of 6. That score was based on a scale ranging from 0-15 with a score of 6 meaning an inability to make informed decisions. *Needed extensive help and two staff to assist with transfers. *Did not walk and used a wheelchair.</p> <p>Review of resident 3's 1/6/14 care plan revealed: *She was "At risk for falls related to impaired balance, diagnosis of dementia with potential for safety awareness difficulties, multiple med [medication] use, use of antidepressant/antipsychotic. Dx [diagnosis] depression/anxiety." *"Resident refuses leg straps on sit stand lift. Resident educated on risk factors. date initiated 11/18/2013."</p> <p>Review of the above resident's 1/6/14 Lift/Mobility Assessment for Residents revealed she needed the Sara lift (a brand of sit-to-stand lift) with the</p>	F 323		

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F 323	Continued From page 9 assistance of two staff. No further assessment updates were found. Interview on 8/20/14 at 4:15 p.m. with certified nursing assistant G revealed she: *Had used the Sara lift to transfer resident 3. *Usually used the leg straps on the lift but sometimes had not. Interview on 8/20/14 at 5:00 p.m. with the director of nursing revealed she was not aware the Lift/Mobility Assessment had not been updated. It was normally updated quarterly or with significant changes. Interview on 8/21/14 at 10:10 a.m. with the administrator revealed nursing staff completed the lift assessments per the MDS assessments. No policy for the use of the above mentioned lift existed. Review of the August 2013 manufacturer's instructions revealed: *The lower leg straps of the Sara lift "are used to ensure that the lower parts of the resident's legs stay close to the knee support." **"An assessment must be made for each individual resident being raised by the SARA 3000 (lift) by a medically qualified person as to whether the resident requires the lower leg straps when using the standing sling. Use as necessary."	F 323			
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	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/21/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 10 of disease and infection.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Implement their surveillance portion of their</p>	F 441	<p>F441 1a) Implementation of facility's surveillance protocol not required as rashes re-evaluated by facility's Medical Director on 8/22/14 who ruled out diagnosis of scabies for all affected residents* (6, 15, 16, 17 and 18). <i>JT/SDDH/MF</i></p> <p>Reintroduce facility's infection surveillance policy and procedure, establish tracking logs and maps by the infection control nurse by 9/19/14.</p> <p>Directed in-service by 9/19/14 for all nursing staff regarding infection control surveillance; including identification of infections and patterns.</p> <p>DNS will monitor the monthly infection control logs and surveillance reports and report findings at monthly QAPI committee meetings</p> <p>1b) Educated CNA C with proper handling of wipes, washcloths, peri-care with catheter and application of topical powders on 9/8/14 . All CNAs will be educated on the proper handling of wipes, washcloths, peri-care and application of topical powders by 9/19/14.</p> <p>DNS or designee will audit the delivery of personal hygiene care with a focus on peri/catheter care for 3 residents weekly x 4 weeks; monthly x 2;</p>		

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F 441	<p>Continued From page 11</p> <p>infection control program in the presence of a known or suspected scabies infection (an itchy, highly contagious skin disease caused by an infestation of an itch mite that is spread through direct contact).</p> <p>*Identify a pattern of infection for five of five sampled residents (6, 15, 16, 17, and 18) with known or suspected scabies infections resulting in the potential of exposure to all residents of the facility to a highly infectious disease.</p> <p>*Appropriately bathe or provide personal care for one of three sampled residents (2) with a urinary catheter resulting in the potential for an increased risk of urinary tract infections (UTI).</p> <p>*Ensure proper cleaning techniques and chemicals would be used by housekeeping and bath aides in the event of a Clostridium difficile (C-diff) infection resulting in the potential for the spread of infection from a failure to have been aware of proper disinfection.</p> <p>*Ensure five of five laundry room shelves had cleanable surfaces.</p> <p>Findings include:</p> <p>1a. Random interview on 8/19/14 with certified nursing assistant (CNA) K during the initial tour revealed two residents had active rashes (15 and 18). Those residents were roommates of the facility.</p> <p>Confidential interview on 8/21/14 regarding resident 16 revealed:</p> <p>*He had recently moved from the Alzheimer's unit to the south wing.</p> <p>*He had shared a room with a resident who had a known rash.</p> <p>*(Confidential interviewee) had heard there had been other residents with rashes and possibly scabies.</p>	F 441	<p>reporting findings to QAPI committee every month with recommendations to follow.</p> <p>1c) Explained risks of bathing with urinary catheters to resident #2 on 8/21/14 who voiced understanding and will consider showering vs. whirlpool baths. <i>* BY FAMILY JK/SDDH/ME</i></p> <p>Educate all residents with urinary catheters by 9/19/14 regarding the risks of bathing with an indwelling catheter and document and care plan resident wishes.</p> <p>DNS or designee will audit newly admitted residents with indwelling catheters for their understanding of bathing risks and preferences x 3 months.</p> <p>1d) Currently there are no residents in facility diagnosed with C-diff. Maintain supply of bleach in facility. Educate nursing staff regarding the contraindication of using whirlpool baths with residents with a diagnosis of C-diff. by 9/19/14. Educate CNAs, housekeepers and laundry staff on the proper cleaning protocols to disinfect for C-diff. by 9/19/14. ED or designee will audit the availability of bleach within the facility. ED or designee with audit the knowledge/understanding of the proper protocol for the decontamination of C-</p>		

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F 441	<p>Continued From page 12</p> <p>*They were concerned the abdominal rash he had was scabies.</p> <p>Interview on 8/21/14 at 1:55 p.m. with CNA C regarding residents 6, 15, 16, 17, and 18 revealed: *Resident 17 had been admitted with a rash last fall. *He was the first resident to have a rash, followed by residents 6, 15, 16 and 18. *The residents had lived next door to one another in the facility and had shared a bathroom.</p> <p>b. Review of the resident 17's medical record revealed: *He had been admitted on 10/13/13 with a rash on his upper and lower legs. *Several medical treatments had been tried from October 2013 through February 2014 without success. *On 12/5/13 the resident was noted by nursing staff to have increased behaviors. He had documentation as follows: -"Wandered throughout the facility and grabbed any cream or lotion he could find and put on his skin. -Skin fiery red. -Resident tried to call ambulance so he could get out of here. -Burning and itching all night. No relief could be obtained. -Resident in extreme discomfort and whole body reddened." *He had been seen by dermatologist H (skin condition doctor) on 2/4/14. At that time he was diagnosed with "scabies with itching." *He had been seen on 2/26/14 by doctor I and had been noted to have "dramatic improvement. Has had no itching for a week or two."</p>	F 441	<p>diff with bleach through the interview of 5 facility and contract staff members x 4 weeks; monthly x 2.</p> <p>1e) The five shelves for clean linen storage in laundry room were painted on 9/3/2013 to create a cleanable surface. All linen storage shelves were examined by Maintenance supervisor and DNS on 8/29/14 to ensure cleanable surfaces. Staff will be educated by 9/19/2014 to report any uncleanable surfaces to maintenance personnel. Maintenance supervisor or designee will audit storage surfaces monthly x 3. Results of these audits will be presented by the Maintenance supervisor to the monthly QAPI committee for review and recommendation.</p>	9/19/2014

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F 441	<p>Continued From page 13</p> <p>*He had been seen again on 3/12/14 by physician's assistant (PA) J. "After his treatment for scabies, the resident had said he felt wonderful and had not itched."</p> <p>Review of resident's 6, 15, 16 and 18's medical records revealed:</p> <p>*Resident 15: -He had developed a rash on his back on 12/11/13. -He had developed a rash on his feet and abdomen on 2/5/14. -He had been treated with Ivermectin on 2/26/14. -He had a physician's note dated 3/5/14 regarding his abdomen stated that "it looked good."</p> <p>*Resident 6: -Had developed a rash on his abdomen on 12/18/13. -On 12/31/13 the rash had been beneath his breast and his abdomen. -On 1/15/14 his rash had been on the front of his chest. -On 1/27/14 he had been treated with Ivermectin and Elimite (scabies treatments). -The rash had "totally resolved" on 2/26/14.</p> <p>*Resident 18: -Had developed a rash on 2/19/14 and had been treated for scabies. -His rash had resolved on 2/26/14. -His rash re-developed on 5/21/14. -PA J had recommended a treatment for scabies on 6/18/14 if he was not any better.</p> <p>*Resident 16: -He had developed a rash on 8/19/14. -He had been a roommate of resident 6 prior to moving off the Alzheimer's unit to the south wing.</p> <p>Review of the provider's surveillance reports from</p>	F 441			

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F 441	<p>Continued From page 14</p> <p>January 2014 through August 2014 to date revealed no residents had been documented as having had scabies in the scabies section of the report.</p> <p>Review of the August 2012 Scabies policy revealed:</p> <ul style="list-style-type: none"> *The purpose was to "treat residents infected with and sensitized to scabies and prevent the spread to other residents and staff." **"Incubation is 2-4 weeks for a person with no previous exposure." **"Previous exposures develop more rapid symptoms of 1-4 days after re-exposure." *Common locations included: <ul style="list-style-type: none"> -Armpits or under the breasts. -Around the waist. -Between fingers and on the palms of the hands. -Inner thighs, groin, and buttocks. -The front of the wrists and elbows. -On body parts that would have come in contact with infected linens. -The upper back. -On the hands of employees. **"Diagnosis is often made with only signs and symptoms present." *Contact precautions should be used for twenty-four hours after treatment had begun. *Residents who shared rooms should be examined. If signs and symptoms had been present, then treat. If not, daily assessments should have been made until the rash had resolved. *Staff should have: <ul style="list-style-type: none"> -Removed four sets of clothing, then placed them in a bag and sent them to laundry. -Placed remaining clothing in a bag, labeled it, and sealed the bag for fourteen days. 	F 441		

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F 441	<p>Continued From page 15</p> <p>Review of the provider's October 2009 Infection Control policy revealed: *The objective was to: -Prevent, detect, investigate, and control infections. -Maintain a safe, sanitary environment for personnel, residents, families, and the general public.</p> <p>Interview on 8/21/14 at 4:00 p.m. with the director of nursing (DON) and the administrator regarding the above residents' rashes revealed: *They had not followed their scabies policy as they "had not been sure" it had been scabies that caused the rashes. *The DON agreed: -There had been either a diagnosis of scabies, or the possibility of scabies documented in the residents' medical records. -She stated the physicians told her they had not known what caused the rash. *The DON could not provide documentation by the end of the survey to support her conversations with the physicians. *The administrator agreed there were no entries on the surveillance report for scabies from January 2014 to August 2014. *She further agreed the scabies policy had not been followed.</p> <p>2a. Observation on 8/20/14 at 10:45 a.m. of resident 2 during personal care of her urinary catheter provided by CNA C revealed: *The CNA put the wipes and washcloth into the dirty sick to moisten. *She had not cleaned around the catheter. *She proceeded to sprinkle anti-fungal powder on the resident's private area that was to be used under skin folds on her abdomen.</p>	F 441		

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F 441	Continued From page 16 Interview later that same day at 1:30 p.m. with CNA C revealed: *She was unaware she should not place clean linens in a dirty sink and proceed to use them for personal care. *She was unaware she should not use powder over her private area as that had not been ordered by the physician. b. Interview on 8/20/14 at 1:10 p.m. with CNA B who bathed resident 2 on bath days revealed: *The resident would have normally received a bath. She had not liked showers. *She was unaware submerging a resident who had a urinary catheter in bathwater was not recommended due to the increased risk for infection. c. Interview on 8/20/14 at 2:30 p.m. with the DON regarding resident 2 revealed: *She agreed personal care performed by CNA C had not been appropriate catheter care. *She was unaware the resident received baths in the whirlpool tub versus the shower. *She was unaware if the resident had been informed of her increased risk for infection associated with bathing in a tub while she had a urinary catheter. *She agreed those risks needed to be discussed with the resident and documented in her medical record if she wished to continue receiving baths. 3. Interview on 8/19/14 at 1:30 p.m. with housekeeper D revealed she had been aware she would need to use bleach on surfaces to prevent the spread of a C-diff infection. She stated she had been told they had none in the facility.	F 441			

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F 441	<p>Continued From page 17</p> <p>Interview on 8/19/14 at 1:40 p.m. with housekeeping and laundry supervisor E and again at 1:50 p.m. with an unidentified laundry aide and supervisor E regarding the above mentioned infection prevention revealed: *Housekeeping should use bleach when cleaning surfaces that had been exposed to C-diff. *The unidentified laundry aide stated they (housekeeping) had no bleach available in the facility to use for a C-diff infection and had not had any on hand for a very long time. *The housekeeping supervisor had been unaware they had not stocked bleach as a housekeeping supply. She stated they should have had it and she would need to order some right away.</p> <p>Interview on 8/19/14 at 2:00 p.m. with housekeeper and laundry aide F revealed she was unaware what cleaner to use if there was a resident with an active C-diff infection.</p> <p>Interview and manufacturer's guideline review on 8/20/14 at 1:10 p.m. with CNA B regarding the cleaning and disinfecting of the whirlpool tub and showers in the facility revealed she: *Had never used bleach to disinfect after a resident who had been known to have a C-diff infection. *Had always used the quaternary disinfectant (contains quaternary ammonia) to disinfect between baths or showers. *Was unaware if the disinfectant was recommended for use on a C-diff infection. *Agreed in viewing the 2012 leaflet provided with the cleaner labeled A-456 II Disinfectant Cleaner that it had not listed C-diff as a bacterium it would have been effective against. *Was unaware bleach was recommended for use</p>	F 441		

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F 441	<p>Continued From page 18 on C-diff infections.</p> <p>Review of the provider's October 2013 Clostridium Difficile policy revealed the environment should be disinfected with a disinfecting agent recommended for C-diff.</p> <p>Review of the provider's October 2009 Infection Control policy revealed "All personnel will be trained on the infection control policies and practices." That included "where and how to find and use pertinent procedures and equipment related to infection control."</p> <p>Surveyor: 32331 4. Observation on 8/19/14 at 2:00 p.m. in the clean linen room located next to the laundry area revealed: *All five shelves contained multiple areas of unfinished wood. *Those shelves contained clean linen for residents that consisted of: -Gowns. -Cloth protectors. -Soakers (pads used on resident's beds). -Pillows. -Bedspreads. -Tablecloths.</p> <p>Interview on 8/19/14 at the same time and location as the above with the maintenance supervisor regarding the five shelves that contained clean linen revealed he: *Agreed the shelves were an uncleanable surface with multiple areas of unfinished wood. *Agreed the shelves had the potential of cross-contamination (bacteria transferred from one area to another).</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>Interview on 8/20/14 at 2:50 p.m. with the administrator in the clean linen room located next to the laundry area revealed she agreed the shelves were an uncleanable surface with multiple areas of unfinished wood.</p> <p>Review of the provider's October 1994 Folding, Storing, and Distributing Clean Linen policy revealed linen was to have been stored on clean, disinfected shelves.</p>	F 441		
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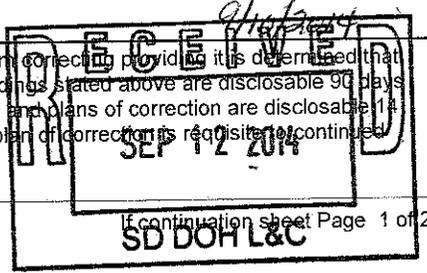
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/19/14. Golden LivingCenter - Redfield (building 01) was found not in compliance 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>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>	
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 ten 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 8/19/14 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>K038 Delayed egress instructions ("Push until alarms sounds, door can be opened in 15 seconds") was ordered from Direct Supply 9/5/2014 with ship date of 9/23/2014 and will be placed at the main entrance exit upon arrival of the sign. A temporary paper sign with the above stated information was put in place on 9/9/2014.</p> <p>All doors with delayed egress function will be identified and delayed egress signage will be visible at each door equipped with delayed egress.</p> <p>Monthly Preventative Maintenance (PM) checks will be implemented by the Maintenance personnel to ensure delayed egress signage remains in place.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Debra M. Gaugh</i>	TITLE <i>Interim NHA</i>	(X6) DATE <i>9/12/2014</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 114 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite for continued program participation.



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

PRINTED: 08/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/19/2014
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 1 maintenance supervisor at the time of observation revealed that magnetic lock was activated between the hours of 6:30 p.m. and 7:00 a.m. for security purposes. Further interview revealed that door was also equipped with a delayed egress feature. That feature would provide egress 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." That signage is required on all marked exits utilizing the delayed egress feature. The maintenance supervisor revealed he was aware of that requirement. He indicated that doors delayed egress signage had been missed at the time the magnetic locks were installed.	K 038	The Maintenance personnel will report the PM findings to the QAPI committee monthly x3 months. The ED or designee will audit the PM findings once a month x3 months to ensure compliance.	9/19/2014	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469
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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) COMPLETION DATE
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K 000	<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 8/19/14. Golden LivingCenter - Redfield (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dee McLaugh</i>	TITLE <i>Nursing Home Administrator</i>	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing its determination 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 15 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.

RECEIVED

SEP 23 2014

SD DOH L&C

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SEP 12 2014

SD DOH L&C

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PRINTED: 09/02/2014
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469
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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 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 8/19/14 through 8/21/14. Golden LivingCenter - Redfield was found not in compliance with the following requirement: S236.	S 000	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.	
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: 34030 Preceptor: 18560 Based on record review, interview, and policy review, the provider failed to complete	S 236	S236 The two step TB test will be completed for Resident #4 and Resident #7. The Infection Control nurse or designee will audit all resident records to ensure all residents have received the Two-step TB testing process, if not clinically contraindicated. The licensed nurses will provide two-step TB testing for all resident found out of compliance. All residents have the potential to be affected. Licensed nurses will be educated by the Infection Control nurse or designee by 9-19-14 re: the required TB testing process and compliance with the requirement is long term care nursing facilities.	

Addendums noted with an asterisk per 9/14 telephone to facility interim administrator. JTD/DMF

**CURRENT JTD/DMF*

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

Rebra McLaugh

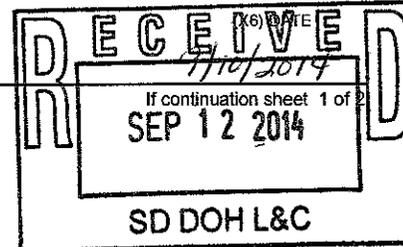
TITLE

Interim NHA

STATE FORM

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/21/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469
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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 236	<p>Continued From page 1</p> <p>tuberculosis (TB) assessments for 2 of 12 sampled residents (4 and 7). Findings include:</p> <p>1. Review of resident 4's medical record revealed: *He was admitted on 5/14/14. *No documentation for a TB assessment was found.</p> <p>Interview on 8/20/14 at 5:00 p.m. and on 8/21/14 at 9:00 a.m. with the director of nursing (DON) revealed she had not found a TB assessment for resident 4. She would initiate one right away. She agreed one should have been done.</p> <p>Review of the undated provider's Tuberculosis Exposure Control Plan policy revealed "all new admissions will receive a 2-step Mantoux PPD (tuberculosis) test."</p> <p>Surveyor: 18560</p> <p>2. Review of resident 7's medical record revealed: *He was admitted on 2/15/14. *He received the 1st step TB skin test on 2/15/14. *No other documentation was found regarding the 2nd step of the TB test.</p> <p>Interview on 8/20/14 at 3:50 p.m. with the infection control nurse revealed if resident 7's TB record had not been with his admission papers from the hospital then the 2nd step had not been done.</p> <p>Interview on 8/20/14 at 4:00 p.m. with the DON confirmed there was no documentation resident 7 had completed both TB test steps.</p>	S 236	<p>Infection control nurse will audit all new admissions for two-step TB testing compliance. The Director of Nursing Service (DNS) or designee will perform a random audit of 25% of all admissions to ensure compliance. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.</p>	<p><i>1 MONTHLY</i> <i>JTS/DON/ME</i></p> <p><i>done</i> <i>9/19/2014</i></p>