

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

ORIGINAL

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

| 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 03/05/2015 |
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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 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS | F 000 | | |
| F 250 SS=D | <p>Surveyor: 18560 A recertification survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/2/15 through 3/5/15. Golden LivingCenter - Clark was found not in compliance with the following requirements: F250 and F323.</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on interview, record review, and policy review, the provider failed to ensure documentation of social services being provided for two of five sampled residents (1 and 3) with symptoms of depression. Findings include:</p> <p>1. Interview on 3/3/15 at 5:00 p.m. with resident 1 and his daughter revealed: *His wife had died in November 2014 and it had been a very difficult loss for him *He had been admitted in November 2014 from his home with the hope of returning to his home at that time. *Since his admission he had two heart procedures including a valve replacement. *He had gone through some very down times in the past couple months and for awhile had not</p> | F 250 | <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 Dumin TITLE: Executive Director (X6) DATE: 4/13/15

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.

APR 14 2015
If continuation sheet Page 1 of 9
SD DOH L&C

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| F 250 | <p>Continued From page 1 gotten out of bed.</p> <p>Review of resident 1's 1/2/15 and 2/13/15 Minimum Data Set (MDS) assessments revealed he had: *A decline in interests. *Felt down. *Decreased energy. *A change in sleep pattern. *Felt bad about himself.</p> <p>Review of resident 1's 2/27/15 care plan revealed: *Problem: "At times I feel sad and hopeless. Have no energy. Have no appetite. Can't sleep or having trouble falling asleep. I have had thoughts that I would be better off dead some days, but I would never hurt myself in any way." *Interventions: -"May see a counselor [name of agency] per physician orders. -Medications that help with depression and sleep. -Please tell my doctor if my symptoms are not improving to see if I need a change in my medication. -Take the time to discuss my feelings when I'm feeling sad." *There were no specific social service interventions to assist him with grief over loss of wife, adjusting to the facility, sense of hopelessness, and monitoring for prevention of self harm.</p> <p>Review of resident 1's social services (SS) progress notes revealed: *2/18/15 "Visited with ___[family member] regarding doctors order for ___[name of counseling agency] evaluation/consult. Resident having s/s [signs and symptoms] of increased</p> | F 250 F250 | <p>1. On March 23, 2015 Social Services was educated by Social Worker Consultant on documenting how we are assisting and purposefully meeting with residents (1,3) with grief over loss of spouse, adjusting to the facility, sense of hopelessness, and monitoring for prevention of self harm. A review of current residents will be completed to identify similar types of medically related social services concerns.</p> <p>2. Directed In-service training will be by April 3, 2015 with the Administrator and Social Services to review and revise as necessary the job expectations for the position of social services. In-service to be provided by Social Worker consultant.</p> <p>3. Administrator or designee will perform random audits to ensure Social Services is documenting how we are assisting and purposefully meeting with residents with grief over loss of spouse, adjusting to the facility, sense of hopelessness, and monitoring for prevention of self harm. Audits will be completed weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented by the administrator or designee to the monthly QAPI committee for review and recommendations.</p> | 04/24/2015 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 250 | <p>Continued From page 2</p> <p>depression. Expressing verbal statements of wishing to die."</p> <p>*2/20/15 "Resident score of 14 indicates moderate depression. He did state that he had thoughts that he would be better off dead, but states that he would not harm himself in any way. Very tired this morning, Eyes closed most of the time during the interview."</p> <p>*2/24/15 "Resident was seen today for the first time by ____ [name of counseling agency]."</p> <p>*Additional notes included assessments that were completed related to mood and behavior or Medicare requirements, but there was no documentation of interventions.</p> <p>*There were no notes indicating SS was purposefully meeting with the resident to support the resident with the adjustment to the facility, follow-up on the counseling that had been provided, assisting with the grief counseling, and putting measures in place to ensure the safety of the resident from self harm.</p> <p>Interview on 3/4/15 at 10:00 a.m. with the SS director regarding resident 1 revealed she:</p> <p>*Had been in her position about seven months and was continuing to learn her responsibilities.</p> <p>*Had met almost daily with the resident and was aware that he had gone through a lot of loss recently and was showing signs of depression.</p> <p>*Tried to get him to look at the bright side of things but acknowledged he needed an opportunity to grieve the loss of his wife and his many health changes.</p> <p>*Agreed the SS documentation had not reflected the support that resident had received.</p> <p>2. Review of resident 3's 12/24/14 quarterly and 1/13/15 significant change MDS assessments revealed the resident:</p> | F 250 | | | |

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| F 250 | <p>Continued From page 3</p> <ul style="list-style-type: none"> *Exhibited decreased energy. *Moved slowly. *Felt down. *Was tired. *Had a decreased appetite. *Felt bad about herself. <p>Review of resident 3's medical record revealed she received psychological services every two weeks. A random review of those reports revealed:</p> <ul style="list-style-type: none"> *12/30/14 "Pt [patient] remains with feelings of daily unhappiness, worthlessness, hopelessness, depressed and anxious mood/affect [lack of emotion] related to the loss of her independence." *2/12/15-"Pt [patient] observed with depressed mood and affect. Increased lethargy [decreased energy]. Pt complained of fatigue (tired) and loss of interest." *2/24/15 "Pt [patient] was observed with increased depressed mood. Resident reports increased depression and loss of interest with quality of life, decreased contact with family." <p>Review of resident 3's 8/31/12 care plan revealed:</p> <ul style="list-style-type: none"> *Problem: "She had a potential for depression due to expressions of depressed feeling down and increased fatigue. Uses antidepressant and will express sadness at times." *There were no discipline specific interventions to assist the resident in coping with her depression. <p>Review of resident 3's 1/14/15 Mood and Behavior status revealed she:</p> <ul style="list-style-type: none"> **Exhibited mood problems. *Had told the nursing staff once that she thought she would be better off dead, but denied ever having thoughts of hurting herself. | F 250 | | |

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| F 250 | <p>Continued From page 4</p> <p>*Was less interested in personal grooming but still takes care of self for the most part. *Slept much of her day and was out for meals."</p> <p>Interview on 3/4/15 at 10:00 a.m. with the SSD regarding resident 3 revealed she: *Had been sick in January, and since then she had not resumed her previous level of activity. *Seemed depressed. *Was seen routinely by a counselor. *The counselor usually talked to the SSD after her visit, but never talked to the staff about how to support her visits in-between each one. *Did not document visits she made with residents routinely. *Confirmed her documentation would not have supported her visits with the resident.</p> <p>3. Review of the provider's 2/26/15 social services interdisciplinary progress notes policy revealed: **The SS staff will document interventions provided upon admission and throughout the resident's stay in the medical record. The frequency of interventions will be determined by each individual resident's needs. Interventions involving another discipline or requiring their immediate awareness will be documented upon identification provision of the intervention, including but not limited to: -Death of a family member/friend/roommate. -Significant increases in mood indicators, and/or behavioral symptoms. -Significant change in functional or health status impacting mental and/or psychosocial status. -Referrals for psychological services. *At a minimum SS notes will contain the following: -Description of resident's behavior, status or data.</p> | F 250 | | | |

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| F 323 | <p>Continued From page 6 from one area to another.</p> <p>Review of resident 6's 2/2/14 fall risk assessment showed a fall in the past thirty days and assistive devices used were a walker and a wheelchair. Interventions included: "Ensure balance, assist in transfer with two staff, call light available, and pressure mat next to the bed."</p> <p>Review of resident 6's 3/26/14 care plan included: *At risk for falls related to new environment, periods of confusion, and weakened physical condition. Interventions included "footwear to prevent slipping while up" and "gait belt with all transfers."</p> <p>-Hand written entries underneath that read: "Fell out of bed 5/4/14" with intervention "Resident to wear gripper socks while in bed." -5/30/14 fall in bathroom with intervention "Pressure alarm to bed 5/30/14." *The resident currently had a bladder infection and was occasionally incontinent (inability to control urine) and needed assistance to go to the bathroom.</p> <p>Review of resident 6's nurses notes from 5/1/14 through 5/30/14 revealed: *On 5/3/14 she "Was alert with periods of confusion and forgets to wait for assistance. Has TABS [a personal alarm device to help prevent fall] alarm on for safety. Was able to transfer with supervision, dress self and toilets with supervision or assist of one." -Preparations were being made to move her back to the assisted living. *On 5/4/14 she fell out of bed without injury. "Resident has TABs but removes them." -Care plan was updated to include "making sure the resident was wearing her gripper socks at all</p> | F 323 | | | |

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| F 323 | <p>Continued From page 7 times."</p> <p>*On 5/9/14 she was walking with walker only and with supervision and was able to transfer and toilet herself.</p> <p>*On 5/28/14 she had a bladder infection and continued to be alert with confusion and was forgetful.</p> <p>*On 5/30/14 she fell in the bathroom. That fall had resulted in an injury of a fractured left leg.</p> <p>Review of resident 6's 5/28/14 change in condition Minimum Data Set care area assessment revealed: *She needed physical assistance of one staff person to transfer out of bed and to use the toilet. *She was occasionally incontinent.</p> <p>Review of a 5/31/14 event report regarding resident 6 sent to the South Dakota Department of Health revealed: *She had a fall on 5/30/14 resulting in a fracture. *The five day investigation report concluded: -"Resident had been asleep in bed thirty minutes prior to fall. Has TABs monitor but alarm was not sounding at time of fall. Resident is encouraged to wear gripper socks to bed.... but chooses not to. Resident has also been noted to remove TABs monitor at times...and rarely uses call light for assistance." -Was found on floor of bathroom and had been incontinent of urine, with the floor of the bathroom wet with urine. -"Resident does have a history of falls, impaired safety awareness, and dementia."</p> <p>Review of 5/30/14 Facility Verification of Investigation report of resident 6's fall revealed along with the report of the fall there were two interviews with staff. Those staff interviews had</p> | F 323 | | | |

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| F 323 | <p>Continued From page 8</p> <p>stated the resident was known to take off or remove her TABs alarm and attempted to walk without assistance.</p> <p>Review of resident 6's 2/17/15 care plan revealed:</p> <ul style="list-style-type: none"> *She was now a permanent resident of the nursing home due to her need for increased care. *Her depression had worsened. *She no longer used a walker and was in a wheelchair. <p>Interview on 3/5/15 at 11:45 a.m. with the director of nursing and the administrator regarding resident 6's falls revealed:</p> <ul style="list-style-type: none"> *No change in interventions regarding the TABs monitor had been made between the falls on 5/4/14 and 5/30/14. *A pressure alarm had been added to her bed after the 5/30/14 fall. *When asked by this surveyor why no further interventions had been done when the resident was known to remove her alarm they replied "What else should we have done?" <p>Review of the provider's 1/22/15 Falls Management Guideline policy revealed:</p> <ul style="list-style-type: none"> *"Residents are assessed for fall risk and evaluated for a prevention plan of care." *"Following a resident's fall and assessment for injury, appropriate interventions are implemented. (See tool: Resource for Resident Interventions to Prevent Falls)." | F 323 | | | |

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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/4/15. Golden LivingCenter-Clark was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 | | | |

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

Margaret Sumner *Executive Director* *3/27/15*

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If continuation sheet Page 1 of 1

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South Dakota Department of Health

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| S 000 | Initial Comments Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 3/2/15 through 3/5/15. Golden LivingCenter - Clark was found not in compliance with the following requirements: S210 and S236. | S 000 | Addendums noted with an asterisk per 4/2/15 telephone to facility administrator *DON. PEISDDOH/MF | 4/24/2015 |
| S 210 | 44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on employee file review and interview, the provider failed to ensure five of five new employees (A, B, C, D, and E) were evaluated by a health professional for freedom from communicable diseases. Findings include: | S 210 | S210 1. All new hires will complete form titled "Employee Health Information Post-Conditional offer" and will be signed by Licensed Health Professional Name/Title within 14 days of employment. *Employees A, B, C, D, and E have been reviewed. PEISDDOH/MF 2. Staff will be educated by Administrator by April 3, 2015 for the need for all new hires to have a signed and completed form titled "Employee Health Information Post-Conditional offer" . 3. Executive Director or designee will conduct audits on new hires to ensure form "Employee Health Information Post-Conditional offer" is signed and complete. Audits will be weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented to the monthly QAPI committee for review and recommendations *by the executive director or designee PEISDDOH/MF <i>*all PEISDDOH/MF</i> | |

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

Margaret Sum

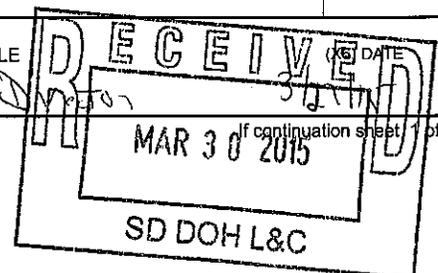
TITLE

Executive Director

STATE FORM

6899

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If continuation sheet of 5

South Dakota Department of Health

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| S 210 | <p>Continued From page 1</p> <p>1. Review of employee files A, B, C, D, and E revealed: *They had been hired within the past four months. *Each employee file had a form titled Employee Health Information Post-Conditional offer. -Those forms had not been completed. -The last statement on those forms read "I certify that I evaluated this form and the employee is free from reportable communicable diseases." with a signature line for a Licensed Health Professional Name/Title. -That had not been signed on any of the new employee forms.</p> <p>Interview on 3/5/15 at 9:00 a.m. with the director of nursing and the administrator revealed: *They confirmed the above forms had not been completed or signed. *They did not have a policy but their expectation would have been to follow the state requirements for completing the health evaluation on new employees.</p> | S 210 | | |
| S 236 | <p>44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows:</p> <p>(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</p> | S 236 | | |

South Dakota Department of Health

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| 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 03/05/2015 |
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| NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CLARK | STREET ADDRESS, CITY, STATE, ZIP CODE 913 COLONEL PETE ST 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 |
|--------------------|---|---------------|---|--------------------|
| S 236 | <p>Continued From page 2</p> <p>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;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 26180 Based on employee file review, interview, and policy review, the provider failed to ensure three of five sampled new employees (B, C, and D) received their two-step tuberculin (TB) skin test within fourteen days of being hired or had necessary documentation for previous TB skin tests that had been completed. Findings include:</p> <p>1. Review of employee B's personnel file revealed: *Her date of being hired was 11/18/14. *She had a one-step TB skin test without a date when it had been administered, but it had been read on 12/24/14. *She did not have a second step completed. *The TB summary record she had at her previous employment revealed she had a one step TB skin test on 12/14/13. The second step had not been completed until 6/9/14.</p> <p>2. Review of employee C's employee file revealed: *She had been hired on 1/26/15. *She received a one-step TB skin test on 1/26/15. She did not receive the second step. *Her documented immunization record prior to having been hired revealed she had a one-step TB skin test on 10/20/14. She had never had the</p> | S 236 | <p>X [REDACTED] PEKSDDH/MF</p> <p>X [REDACTED] see page 4 PEKSDDH/MF</p> <p>X [REDACTED] PEKSDDH/MF</p> <p>X [REDACTED] PEKSDDH/MF</p> <p>X [REDACTED] PEKSDDH/MF</p> | |

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| S 236 | <p>Continued From page 3</p> <p>second skin test in the required time frame.</p> <p>3. Review of employee D's file revealed: *She had been hired on 1/6/15. *A one step TB skin test had been completed on 1/6/15 and had been reviewed on 1/9/15. *There was not a second TB step completed. *A review of the employee's immunization documentation revealed she had a one-step skin test on 6/30/14 that was negative, but she had never had a second skin test to complete a two-step skin test.</p> <p>4. Interview on 3/4/15 at 4:45 p.m. with the director of nursing (DON) and the administrator revealed: *The DON was responsible for the oversight of the health screening of new employees. *She understood the requirement was to complete a one-step TB skin assessment if they had only completed a one-step TB skin assessment within the past year. -She was unaware the requirement was for a two-step TB skin test. *She agreed that employees B, C and D's records of previous TB skin tests had not been reviewed and determined to have been appropriately completed.</p> <p>Review of the provider's 12/1/14 TB Infection Control Program policy revealed: ***The facility's TB infection control program includes the early identification isolation and transfer of persons with active tuberculosis. *Screening and surveillance of residents and employees for latent TB infection and active TB as appropriate for the current TB risk classification." *The policy had not addressed the time frame for completing TB skin tests for new employees.</p> | S 236 | <p>*1) Effective immediately Tuberculin screening requirements for all new workers or residents will be followed as written in 44:04:04:08.01. Employee B, C, and D will have a TB skin test completed by April 24, 2015.</p> <p>2) Education by the Director of Nursing will be provided to staff responsible for the administrating and compliance of tuberculin screening will be completed by April 3, 2015.</p> <p>3) Executive Director or designee will conduct random audits of new hires and new residents to ensure compliance with tuberculin screening requirements. Audits will be completed weekly if new hires or residents occur for 4 weeks then monthly for 3 months. (continued pg 5)</p> | * 4/24/15 DEK/DH/MF |

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| | | | <p>* (continued from page 5 #3) Results of these audits will be presented to the monthly QAPI committee by the Executive Director for review and recommendations. PE/SODH/MF</p> | |