

ORIGINAL

PRINTED: 03/01/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2016
--	---	--	---

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	<p>INITIAL COMMENTS</p> <p>Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/16/16 through 2/18/16. Golden LivingCenter - Clark was found not in compliance with the following requirement: F441.</p> <p>F 441 SS=E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</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</p>	F 000	<p><i>*Addendums noted with an asterisk per 3/14/16 per telephone with facility administrator.</i></p> <p>Survey Disclaimer PE/SDDOHTEL 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 <i>Margaret Munn</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3/8/2016</i>
---	------------------------------------	------------------------------

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.

DEFERRED

MAR 09 2016

SD DOH L&C

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

PRINTED: 03/01/2016
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 02/18/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - CLARK	STREET ADDRESS, CITY, STATE, ZIP CODE 201 8TH AVENUE NW CLARK, SD 57225 04/08/2016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	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 1 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: 36413 Based on observation, interview, and policy review, the provider failed to ensure: *Manufacturer's recommendations for disinfecting therapy equipment had been followed for one of one therapy room. *Medical supplies in one of one medical supply room had not expired. Findings include:</p> <p>1. Observation and interview on 2/17/16 at 10:45 a.m. with physical therapy assistant A revealed she: *Used the "spray and wipe" method to clean the therapy room equipment. *Sprayed the equipment and immediately wiped it with a cloth. *Had not been instructed on how to clean the therapy room equipment. *Stated housekeeping cleaned the equipment nightly and on weekends if used by residents. -Therapy staff would let housekeeping know on the weekends if equipment was used.</p> <p>Observation and interview on 2/17/16 at 10:50 a.m. with restorative certified nurse aide B revealed she:</p>	F441	<p>1. On February 18, 2016 therapy staff, was educated by Executive Director on proper cleaning and disinfecting of equipment. A review of the policy and procedure for surface [redacted] - modality equipment and policy and procedure for central supply stock rotation was conducted on March 2, 2016.</p> <p>2. Central Supply was audited and all expired items were removed by March 7, 2016.</p> <p>3. Directed In-service training was held March 2, 2016 by the Executive Director with central supply, DON and interdisciplinary team to review and revise as necessary the policy and procedures for central supply stock rotation. Central Supply will be reviewed for expired product and items will be removed by March 7, 2016. Directed In-service training was held March 2, 2016 by the Executive Director with the therapy staff, DON, and interdisciplinary team to review and revise as necessary the policy and procedure for surface [redacted] - modality equipment.</p> <p>4. Executive Director or designee will perform random audit to ensure therapy equipment is disinfected per manufacturer's recommendations and that central supply items are on a stock rotation and not expired. Audits will be completed weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented by the Executive Director or designee to the monthly QAPI committee for review and recommendations.</p>	
-------	--	------	--	--

**Disinfecting PE/SDDO/HEL*

**disinfecting PE/SDDO/HEL*

**4/8/16 PE/SDDO/HEL*

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

PRINTED: 03/01/2016
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 02/18/2016
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 441	<p>Continued From page 2</p> <ul style="list-style-type: none"> *Used Clorox wipes to wipe down therapy room equipment after resident use. *Could not find the Clorox wipes therapy used. *Agreed the therapy room equipment had not been wiped off today after being used. <p>Interview and observation on 2/17/16 at 11:00 a.m. with the housekeeping supervisor revealed:</p> <ul style="list-style-type: none"> *She had not instructed the therapy staff on how to clean the therapy room equipment between resident use and what disinfectant to be used. *She saw the disinfectant bottle in the therapy room and stated it had been labeled a disinfectant that was no longer used in the facility. *She had not instructed housekeepers on how to clean the therapy room equipment. -Housekeepers had not cleaned the therapy room equipment that the residents used. <p>Interview on 2/17/16 at 11:05 a.m. with the administrator revealed:</p> <ul style="list-style-type: none"> *She expected the therapy room equipment would be cleaned per manufacturer's instructions between residents. *She expected the therapy room would have been cleaned by housekeeping daily. <p>Review of the contracted therapy service's 10/23/14 Surface Disinfection Modality Equipment policy revealed exposure time for disinfectant chemical was ten minutes or to follow manufacturer's recommendations. It did not specify chemicals that were to be used.</p> <p>Surveyor: 32355</p> <p>2. Observation on 2/17/16 at 3:45 p.m. of the clean medical supply room located on the west wing revealed the following expired medical supplies:</p>	F 441			

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

PRINTED: 03/01/2016
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 02/18/2016
--	---	--	---

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 441	<p>Continued From page 3</p> <p>*A box: -Three fourths full of 5 milliliter syringes, expired December 2011. -Full of insulin syringes, expired August 2013. -Half full of oxygen extension tubing with the years of expiration ranging from 2006 through 2010. -Full of 25 foot oxygen extension tubing with the years of expiration ranging from 2006 through 2014. -Half full of nebulizer masks with the years of expiration ranging from 2011 through 2015. *Six nasal feeding tubes, expired July 1999. *Ten suction swabs, expired 12/1/14.</p> <p>Interview on 2/17/16 at 4:20 p.m. with the director of nursing and the business office manager revealed: *The business office manager had been responsible for keeping the medical supply room stocked. *They had: -Not been aware the above medical supplies had expired. -Never checked for expiration dates on any of the medical supplies. -Assumed the supplies were useable if the packages remained intact and un-opened.</p> <p>Interview on 2/17/16 at 4:25 p.m. with registered nurse C revealed she would not have checked any of the medical supplies for expiration dates prior to using them.</p> <p>Review of the provider's 5/21/14 Central Supply policy revealed no procedure in place for ensuring medical supplies had not been used beyond their expiration dates.</p>	F 441		
-------	---	-------	--	--

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

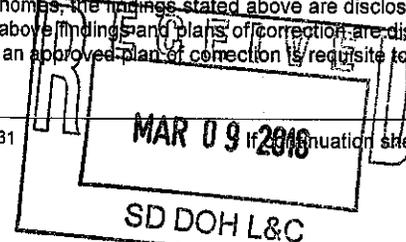
ORIGINAL

PRINTED: 03/01/2016
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/17/2016
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
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/17/16. 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 *Margaret Humm* TITLE *Executive Director* (X6) DATE *3/8/2016*

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



South Dakota Department of Health

ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2016
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/16/16 through 2/18/16. Golden LivingCenter - Clark was found not in compliance with the following requirements: S169 and S210.	S 000	*Addendums noted with an asterisk per 3/14/16 per telephone with facility administrator. PE/SDDO/HCL	
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure two of nine exterior doors (the main entrance and staff entrance door) had been alarmed, locked, or attended at all times to ensure resident safety. Findings include:	S 169	1. Exterior doors will be alarmed or attended at all times to ensure resident safety. 2. Education to staff that all exterior doors need to be alarmed, locked, or attended at all times to ensure resident safety will be conducted by Executive Director by April 8, 2016. Bids will be received for a keypad system for the alarm on the doors. 3. Executive Director or designee will perform random audit to ensure exterior doors are alarmed, locked or attended at all times to ensure resident safety. Audits will be completed weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented by the Executive Director or designee to the monthly QAPI committee for review and recommendations.	*4/8/2016 PE/SDDO/HCL

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

Margaret Armon

TITLE

Executive Director

(X6) DATE

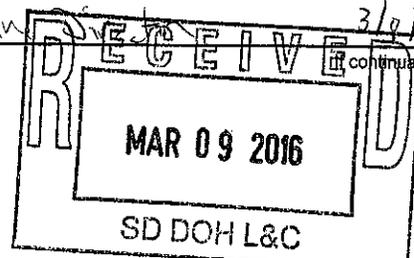
3/9/2016

STATE FORM

6899

SMSB11

continuation sheet 1 of 5



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2016
--	--	--	---

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) COMPLETE DATE
S 169	<p>Continued From page 1</p> <p>1. Observation on 2/17/16 at 2:30 p.m. and at 4:00 p.m. of the staff entrance door revealed: *It was equipped with an audible alarm. *The alarm was not activated at the time of the observation. *When opened the entrance led to the staff parking lot and a large wooded area. *The administrator's office had been within sight distance of that door when she was working in her office. She had not been in her office at the time of the observation.</p> <p>Observation on 2/17/16 at 3:00 p.m. of the main entrance door revealed: *It was equipped with an audible alarm. *The alarm was not activated at the time of the observation. *When opened the entrance led to the visitor parking lot and down a hill. *The social worker's office had been within sight distance of that door when she was working in her office. She had not been in her office at the time of the observation.</p> <p>Interview on 2/17/16 at 4:00 p.m. with the maintenance supervisor revealed: *He confirmed the alarm for the staff entrance door had been de-activated during the day hours. *The alarm for the door would automatically come on at 5:30 p.m. *Any resident who had worn a Wanderguard bracelet (wireless monitoring system for residents at risk of wandering) would activate the alarm. *The main entrance door had been programmed the same as the staff entrance door. *He agreed staff would not have been alerted if a resident without a Wanderguard bracelet had gone out those doors. *He had not known a state rule had existed to ensure an exterior door was to have been</p>	S 169		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2016
--	--	--	---

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) COMPLETE DATE
S 169	<p>Continued From page 2</p> <p>alarmed, locked, or attended at all times.</p> <p>Interview on 2/17/16 at 4:10 p.m. with the administrator confirmed the above observation and interview.</p> <p>Review of the provider's 3/14/14 Door Security policy revealed: ***It is the policy of the facility to provide a safe and comfortable environment to residents, visitors, and associates. Securing doors which lead a path to and from exterior will reinforce our facility's commitment in protecting our population." ***Our alarms for the front and associates doors are at red mode (off) at 18:30 (4:30 p.m.) and back on green mode (on) at 6:00 a.m."</p>	S 169		
S 210	<p>44:73:04:06 Employee Health Program</p> <p>The facility shall have an employee health program for the protection of the residents. All personnel shall 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. Any 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 physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a</p>	S 210		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/18/2016
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

S 210	<p>Continued From page 3</p> <p>communicable stage.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18560</p> <p>Based on record review and interview, the provider failed to ensure two of two sampled employees (D and E) had a health evaluation completed within fourteen days of being hired. Findings include:</p> <p>1. Review of the following employees' personnel records revealed: *Employee D had been hired on 10/15/15. *Employee E had been hired on 11/2/15. *There was no documentation in the above employees' personnel files a health evaluation for free of communicable disease had been reviewed and signed by a health care professional.</p> <p>Interview on 2/18/16 at 12:30 p.m. with the administrator confirmed: *There was no documentation in employee D and E's personnel files a health evaluation for free of communicable disease had been completed within fourteen days of being hired. *An employee recruitment firm had been hired. *She had not been aware the recruitment firm had not completed the health evaluations for newly hired employees.</p>	S 210	<p>S210</p> <p>1. All new hires will complete the form titled "Employee Health Information Post-Conditional offer" within 14 days of employment. Employees D and E have been completed.</p> <p>2. Current employee files have been audited and any missing "Employee Health Information Post-Conditional Offer" forms will be completed by April 8, 2016.</p> <p>3. Facility Business Office Coordinator will be educated by Executive Director by Aril 8, 2016 for the need for all new hires to have a completed form titled "Employee Health Information Post-Conditional offer".</p> <p>4. Executive Director or designee will conduct audits on all new hires to ensure form "Employee Health Information Post-Conditional offer" is complete. Audits will be weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented by the Executive Director or designee to the monthly QAPI committee for review and recommendations.</p>	4/08/2016
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 18560</p> <p>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 2/16/16 through 2/18/16. Golden LivingCenter - Clark was</p>	S 000		<p>*4/8/2016 PE/SPDOH/EL</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/18/2016
--	--	---	---

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) COMPLETE DATE
S 000	Continued From page 4 found in compliance.	S 000		