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

ORIGINAL

PRINTED: 02/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435047		C 02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 *Addendums noted with an asterisk per 3/14/16 per telephone with facility administrator. Surveyor: 32331 JTBDOHEL A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/1/16 through 2/3/16. Golden LivingCenter - Pierre was found not in compliance with the following requirement(s): F371 and F441. Surveyor: 16385 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/1/16 through 2/3/16. Areas surveyed included quality of care/treatment. Golden LivingCenter - Pierre was found in compliance.	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 this 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 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained in the kitchen for: *One of one dishmachine temperature levels for	F 371	**F371** 1. All residents are at risk. Sanitary conditions are maintained in the kitchen. The dish machine has been repaired. A holding thermometer and temperature test strips have been purchased and available. Kitchen vents have been cleaned. 2. The DSM and RD will in-service the dietary staff on the policies and procedures of maintaining a sanitary kitchen. This in-service will include sanitation of dishware with correct temperature sanitation and proper cleaning procedures for cleaning vents on a regularly scheduled timeline.	3/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Philip L Preston — TITLE: Executive Director — (X6) DATE: 2/26/16

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 371	Continued From page 1 hot water sanitization of the dishes and utensils for all residents on oral diets. *Four of twelve vents located above a food preparation area, a dry food storage area, a milk cooler, and a clean dish storage area had been cleaned. Findings include: 1. Observation on 2/2/16 at 8:15 a.m. in the dishmachine area revealed: *The rinse temperature was at 154 to 155 degrees Fahrenheit (F) according to a digital temperature gauge attached to the machine. *A plate affixed to the front on the Hobart dishmachine revealed the rinse temperature had needed to have been 180 degrees F for hot water sanitization. *A level below 180 degrees F had not been adequate for hot water sanitization of the dishes and utensils put through the dishmachine. Interview and observation on 2/2/16 at 8:30 a.m. with the certified dietary manager (CDM) and the maintenance manager revealed: *The dishmachine was a high temperature machine, and it needed hot water for sanitizing the dishes and utensils. *The maintenance manager stated the thermostat on the Hatco hot water booster had gone out about a week ago. -A new thermostat part had been ordered through a local plumber. *The maintenance manager stated a reset button was to have been pushed to increase the rinse hot water temperature on the machine. *After he had pushed that reset button the rinse temperature was at 174 degrees F. *Both agreed a level below 180 degrees F had not been adequate for hot water sanitization of	F 371	In-service will be completed on March 1, 2016. 3. The DSM or designee will complete audits of temperature logs and cleanliness of kitchen vents weekly x 4 and then monthly x 3 to ensure that sanitary conditions are maintained in the kitchen. Results of the audits will be reported by the DSM or designee and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits. JT/SDOH/EL 4. March 22, 2016	

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F 371	Continued From page 2 the dishes and utensils put through the dishmachine. *Both stated the provider did not have a holding thermometer or temperature test strips to verify accuracy of the dishmachine temperature gauge. *Both stated the three compartment sink would be used for manual cleaning of dishes and utensils until a level of 180 degrees F could be obtained for hot water sanitization in the dishmachine. Interview on 2/2/16 at 8:37 a.m. with a contract plumber in the kitchen revealed: *The thermostat part had arrived in his office on 2/1/16. *He had arrived at the facility to install that new part on the Hatco hot water booster attached to the dishmachine. Observation on 2/2/16 at 9:16 a.m. in the dishmachine area of the kitchen revealed the rinse temperatures were at 182 degrees F according to the temperature gauge attached to the machine. Observation and testing on 2/2/16 at 11:10 a.m. in the dishmachine area of the kitchen revealed: *The temperature inside the dishmachine using a holding thermometer revealed a temperature of 169.5 degrees F. *That above temperature needed to have been a minimum of 160 degrees F for the point of contact on dishes and utensils. *The rinse temperature at the above time according to the temperature gauge attached to the machine was at 180 degrees F. Interview on 2/2/16 at 11:25 a.m. with cook A and dietary assistant B in the kitchen revealed:	F 371		

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F 371	Continued From page 3 *They had been unaware of the temperature level required for hot water sanitization of the dishes and utensils being cleaned in the dishmachine. *They had not been instructed on using a reset button on the booster heater attached to the dishmachine if rinse temperature levels had been lower on the dishmachine. *They had not known a rinse temperature of less than 180 degrees F had needed to have been followed-up on by the dietary manager or the maintenance manager immediately. Review of the provider's 1/1/16 through 1/31/16 and 2/1/16 Dishmachine Temperature Log revealed: *From 1/18/16 through 1/31/16 the final rinse temperatures had been less than 180 degrees F with a temperature range of the following: -Ten times at the breakfast meal: 152 degrees F to 179 degrees F. -Nine times at the noon meal: 161 degrees F to 177 degrees F. -Fourteen times at the evening meal: 158 degrees F to 178 degrees F. *On 2/1/16 the following final rinse temperatures had been less than 180 degrees F: -No temperature had been taken at the breakfast and noon meals. -The temperature had been 157 degrees F at the evening meal. *Instructions on the Dishmachine Temperature Log form revealed: -Two or three empty dish racks were to have been put through the dishmachine to raise temperature. -The rinse temperature was to have been observed and recorded before beginning the dishwashing procedures. -Dishwashing was to have been ceased	F 371		

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F 371	Continued From page 4 (stopped) if temperatures were below the required level. -Temperatures were to have been reported that were below required levels to the dietary services manager and/or maintenance immediately. -Action plans for all problems were to have been recorded with a date on the back of the log. -The director of dining services or assigned designee was responsible for monitoring the dishmachine temperature log daily for accuracy and compliance. Review of the provider's undated Dishmachine Use and Care policy revealed: *For a high-temperature machine: -The temperature in the rinse cycle needed to have been maintained at a minimum of 180 degrees F per gauge, 170 degrees F per non-mercury thermometer, or 160 degrees F at point of contact on plates and utensils using a temperature test strip. *The Dishmachine Temperature Log was to have been completed by employees involved in the dishwashing process. -That above form was to have been completed prior to running any item through the dishmachine. *The director of dining was responsible for training and monitoring compliance. *The maintenance department was to have checked and recorded the internal dishmachine temperatures at least once per week. *Test strips were to have been used to verify the gauge temperature at least once a day. *Two or three empty racks were to have been put through the dishmachine to raise water temperature. *The rinse temperature was to have been observed and recorded before beginning the	F 371		

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F 371	Continued From page 5 dishwashing procedures. *Dishwashing was to have been ceased if temperatures were below the required level. *Temperatures were to have been reported that were below required levels to the director of dining manager immediately. *Test strips and a non-mercury holding thermometer were to have been available to assure accuracy. Review of the provider's 9/27/15 job description for the Manager of Dining Services revealed: *The employee was to have managed the operation of the dietary department. *The above operation had included clean-up in accordance with facility policies and appropriate regulations. 2. Observation on 2/1/16 from 4:20 p.m. through 4:45 p.m. in the kitchen revealed: *A moderate accumulation of dust and lint on the vents attached to the ceiling directly above a food preparation area, a milk cooler, and a dry food storage area. *A moderate accumulation of dust and lint on a the vent located above a cupboard that contained clean dishes. Interview on 2/2/16 at 8:00 a.m. with the CDM regarding the above listed areas in the kitchen revealed: *The maintenance manager was responsible for cleaning the vents in the kitchen. *She agreed the vents were located over a resident food preparation area, a milk cooler, a dry storage area, and cleaned dishes. *She agreed those vents had not been cleaned. Interview on 2/2/16 at 8:30 a.m. with the	F 371		

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F 371	Continued From page 6 maintenance manager in the kitchen revealed he: *Had been responsible for cleaning the vents in the kitchen. *Those vents were cleaned on an annual basis. *Agreed the vents were not cleaned and needed to have been cleaned on a more frequent basis. *Had no specific policy on cleaning of those vents in the kitchen.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**F441** **1. All residents are at risk. The facility does establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help to prevent the development and transmission of disease and infection. The concentrator filters for residents 1, 11, 12, and 16 have been cleaned.** and all other residents with oxygen concentrator filters. JT/DOH/EL **2. ED or Designee will in-service Maintenance Supervisor on manufacturers instructions for cleaning oxygen concentrator filters on a weekly basis to ensure a safe, sanitary and comfortable environment is maintained. In-service will be completed no later than March 22, 2016.**	3/22/16

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F 441	Continued From page 7 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Surveyor: 35625 Surveyor: 23059 Based on observation, interview, and manufacturer's instruction review, the provider failed to ensure proper sanitation of oxygen (O2) concentrator filters for four of six observed residents' (1, 11, 12, and 16) O2 concentrator filters. Findings include: 1. Observation from 2/1/16 at 4:40 p.m. through 2/3/16 at 11:10 a.m. of resident 11's O2 concentrator filter revealed it was soiled. The filter had not been cleaned or replaced during that entire observation period. Surveyor: 32331 2. Observation on 2/3/16 at 7:45 a.m. of resident 12's O2 concentrator filter revealed it was heavily soiled. Observation and interview on 2/3/16 at 7:46 a.m. with the certified nursing assistant C in resident 12's room revealed she: *Agreed the O2 concentrator filter was heavily	F 441	3. The ED or Designee will perform audits of 4 oxygen concentrator filters weekly x 4, then monthly x 3 to ensure that a safe, sanitary and comfortable environment is maintained. Results of the audits will be reported by the ED or designee and discussed at *monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits. JT/SDDOH/EL 4. March 22, 2016	

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F 441	Continued From page 8 soiled. *Stated the maintenance manager was responsible for ensuring those O2 filters had been cleaned. Interview on 2/3/16 at 7:55 a.m. with the maintenance manager revealed: *His department was responsible for ensuring the O2 filters had been cleaned. *The filters were scheduled to have been cleaned with weekly room inspections. *There was no documentation regarding the cleaning of the O2 filters. Surveyor: 23059 3. Observation on 2/3/16 at 9:10 a.m. of resident 16's O2 concentrator filter revealed it was heavily soiled. Interview on 2/3/16 at 9:45 a.m. with the director of nursing (DON) revealed the maintenance manager was responsible for ensuring those O2 filters were cleaned or replaced weekly. Surveyor: 35625 4. Observation on 2/3/16 at 10:50 a.m. of resident 1's O2 concentrator filter revealed it was heavily soiled. Surveyor: 23059 5. Interview on 2/3/16 at 11:10 a.m. with the DON revealed they did not have a policy regarding the cleaning of O2 concentrator filters. She provided the surveyor with the manufacturer's instructions for the O2 concentrators. Review of those instructions revealed the filters were to have been removed and cleaned at least weekly.	F 441		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/03/16. Golden LivingCenter-Pierre was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K017, K051, K69, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 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 this 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.	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain corridor separation from use areas at one randomly observed room (activities storage room) in one of five smoke	K 017	**K017** 1. All residents are at risk. The facility does ensure that corridor separation from use areas and all smoke compartments are maintained in accordance with the National Fire Protection Association. The wood studs will be covered with gypsum and the west wall will be finished to the roof deck no later than March 22, 2016.. 2. ED will in-service the Maintenance Supervisor to ensure all repairs are corrected after their identification from inspections. In-service will be completed on March 9, 2016.	3/22/16

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

Philip L Preston — Executive Director — 2/26/16

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K 017	Continued From page 1 compartments. Findings include: 1. Observation at 11:00 a.m. on 2/03/16 revealed the activities storage room was located at the back of the activities office. The storage room was under 50 square feet and had combustible storage items within it. At a six foot high level in the storage room, an opening at the west wall of the storage room to the roof deck was noted. The opening was approximately four feet wide (front to back) in the room and from a height of six feet in the room to the roof deck above it (approximately six feet of open space in height). Checking the space above the opening revealed a louvered opening in the west wall of the space. That opening was in the wall to the dining room and measured approximately 20 inches by 20 inches. The dining room was open to the corridor system. Also, the wood stud wall on the south side of the opening (north walls of the activities office and social services office) was not covered with gypsum board (wood studs exposed). Interview with the maintenance supervisor and executive director at the time of the observation confirmed that finding. The maintenance supervisor revealed the louvered opening was a return air path into the space occupied by the activities storage room to the air handling unit for that area. Further interview with the executive director revealed covering the wood studs with gypsum board and extending a sheathed wall to the roof deck for the activities storage room would effectively separate the dining room/corridor use areas from the storage room. The deficiency affected a single smoke compartment location required to maintain smoketight construction.	K 017	**3. The ED or designee will complete monthly audits x 4 to ensure all smoke compartments are maintained in accordance with the Nation Fire Protection Association. Results of the audits will be reported by the ED and discussed at QAPI for further review and recommendations and/or continuation/discontinuation of audits.** **4. March 22, 2016**	

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K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to maintain the fire alarm system (transmission of supervisory signals). Findings include: 1. Document review on 2/03/16 of the fire alarm report documentation dated 6/17/15 indicated the duct dampers (physical therapy supply x1, physical therapy return x2) in the east wall above the drop-in ceiling in the main lobby did not close upon activation of the fire alarm system. Also, it was noted the 1-1/2 hour fire-rated doors separating the physical therapy area from the	K 051	**K 051** **1. All residents are at risk. The facility does ensure that all fire alarm systems and components are in working order in accordance with the National Fire Protection Agency. New Fire Alarm System will be installed.** **2. ED will in-service the Maintenance Supervisor to ensure that inspection of fire dampers with the fire alarm system is completed and repairs completed if needed following installation of new system. In-service will be completed on March 9, 2016** **3. The ED or designee will audit monthly x 4 to ensure inspection and follow up completed if there are areas of concern with dampers. Results of the audits will be reported by the ED or designee and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.** **4. March 22, 2016.**	3/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	435047		02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - PIERRE	950 EAST PARK STREET PIERRE, SD 57501

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K 051	Continued From page 3 main lobby were magnetically held open and did not release/close upon activation of the fire alarm system. Interview with the maintenance supervisor at the time of the document review revealed the fire alarm panel (Simplex 2001) was installed in 1982. The panel had a bad circuit board that was obsolete and parts to replace it were not available. Interview with the executive director at 4:00 p.m. on 2/03/16 revealed the provider was purchasing a new addressable fire alarm panel to replace the Simplex unit. This deficiency could potentially affect all occupants of the physical therapy and the lobby smoke compartments.	K 051		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to perform required preventive maintenance for the kitchen commercial range hood fire suppression system for the six month inspection. Findings include: 1. Document review at 1:45 p.m. on 2/03/16 revealed the last available inspection report for the kitchen commercial range hood fire suppression system was dated 3/25/15 (another inspection report would have been due by 9/25/15). Inspections of the range hood fire suppression system must be completed not more than six months apart. The report dated 3/25/15 also did not include the hydrostatic date of the fire	K 069	**K 069** **1. All residents are at risk.** **The facility does perform required preventative maintenance for the kitchen commercial range hood fire suppression system for the 6 month inspections. Inspection to include hydrostatic test will be completed no later than March 22, 2016.** **2. ED will in-service Maintenance Supervisor to ensure that inspection of kitchen hood fire suppression system is completed every 6 months in accordance with the National Fire Protection Agency. In-service to be completed on March 9, 2016.**	3/22/16

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K 069	Continued From page 4 suppression system supply tank. There was not any documentation indicating any six year maintenance being performed on the system. That was due in calendar year 2015. Interview with the maintenance supervisor at the time of the document review revealed the contractor had not performed the inspection. The deficiency affected one of numerous requirements for maintaining the kitchen range hood fire suppression system.	K 069	3. The ED or designee will audit semi-annually to ensure inspection and corrections completed if necessary. Results of the audits will be reported by the ED or designee and discussed at QAPI for further review and recommendations and/or continuation/discontinuation of audits. 4. March 22, 2016.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain a 36 inch clear depth of working space in front of two electrical panels in the dietary storage area. A chair and small work table obstructed access to electrical panels in the storage room. Findings include: 1. Observation at 10:00 a.m. on 2/03/16 revealed a chair and small work table were on the floor in front of electrical panels in the dietary storage area. The chair and work table obstructed access to the panels. The floor was not marked to indicate clear space requirements for electrical panels. Interview with the maintenance supervisor confirmed that condition. The deficiency affected one of numerous requirements for maintaining electrical equipment in one of two electrical panel locations.	K 147	**K 147** 1. All residents are at risk. The facility does maintain a 36 inch clear depth of working space in front of two electrical panels in the dietary storage area. The chair and small work table have been removed to access the electrical panels. Marking was placed on the floor at the 36 inch measurement requirement. 2. ED will in-service Maintenance Supervisor to ensure that monthly electrical clearance inspections are completed in accordance with the National Fire Protection Agency. In-service to be completed on March 9, 2016.	3/22/16

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			3. The ED or designee will audit monthly x 4 to ensure all inspections by Maintenance Supervisor are completed. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits. 4. March 22, 2016.	

ORIGINAL

PRINTED: 02/16/2016
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - PIERRE	950 E PARK PIERRE, SD 57501

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S 000	Compliance/Noncompliance Statement *Addendums noted with an asterisk per 3/14/16 per telephone with facility administrator. JT/SDDOH/EL Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 2/01/16 through 2/03/16. Golden LivingCenter - Pierre was found not in compliance with the following requirements: S121 and S296.	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 121	44:73:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain a sanitary working surface in the kitchen (ductwork grease filters and stove gas piping). Findings include: 1. Observation at 10:00 a.m. on 2/03/16 revealed the four stainless steel grease filters situated above the cooking range in the exhaust ductwork had a large amount of lint and grease buildup on them. Interview with the dietary manager revealed the hood and ductwork were on a scheduled quarterly (every three month) cleanup schedule per their corporate guidelines. 2. Observation at 10:05 a.m. on 2/03/16 revealed	S 121	**S 121** 1. All residents are at risk. The facility does maintain a sanitary working surface in the kitchen. The ductwork grease filters and the stove gas piping have been cleaned. 2. DSM and RD will in-service all dietary staff and the Maintenance Supervisor on sanitation of the stainless steal grease filters and gas piping to be cleaned every 2 weeks to ensure sanitary working surfaces are maintained in the kitchen. In-service will be completed on March 1, 2016. 3. The ED or designee will audit stainless steal grease filters and gas piping weekly x 4, then monthly x 3 to ensure sanitary working surfaces are maintained in the kitchen. Results of the audits	3/22/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 2/26/16

FEB 26 2016
SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - PIERRE

STREET ADDRESS, CITY, STATE, ZIP CODE: 950 E PARK, PIERRE, SD 57501

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S 121	Continued From page 1 the natural gas piping at the back of the cooking stove had lint and grease buildup on it. A stainless table with covered snacks (for residents) was situated directly in front of the soiled piping. 3. Interview with the executive director at 3:45 p.m. on 2/03/16 confirmed those conditions. He stated a more frequent schedule for cleaning the filters and the piping would be established.	S 121	will be reported by the ED or designee and discussed at QAPI for further review and recommendations and/or continuation/discontinuation of audits. 4. March 22, 2016.	
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the	S 296	**S 296** 1. All residents are at risk. The facility does ensure at least one cook possesses a current ServSafe Food Protection Program certificate. One cook will be attending ServSafe Food Protection Program on March 16, 2016. 2. RD will in-service DSM/ED to ensure at least one cook possesses a current ServSafe Food Protection Program certificate. In-service will be completed on March 1, 2016. 3. In lieu of auditing at this time the ED will ensure DSM and one cook maintain a current ServSafe certification. Appropriate ServSafe certifications will be reviewed to ensure compliance during monthly QAPI meetings. *by the ED. JT/SDOOHIEL	3/22/16

South Dakota Department of Health

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S 296	Continued From page 2 assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review and interview, the provider failed to ensure at least one cook possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 2/1/16 at 4:30 p.m. with cook A revealed the certified dietary manager (CDM) was the only staff person in the kitchen that had a current ServSafe certificate. Interview and record review on 2/2/16 at 8:00 a.m. with the CDM revealed she: *Was the only staff person in the kitchen that had a current ServSafe certificate. *Review of her certificate revealed an expiration date of 5/29/19. *Had been aware the dietary manager and at least one cook working in the kitchen had needed to have a current ServSafe certificate. *Had planned to have cook A enroll in the earliest class available for ServSafe. Interview on 2/2/16 at 2:45 p.m. with the CDM revealed the provider had no policy on the ServSafe Food Protection Program certificate. Interview on 2/3/16 at 8:30 a.m. with the administrator revealed: *There needed to have been at least one cook that had a current ServSafe certificate.	S 296	4. March 22, 2016.	

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S 296	Continued From page 3 *The regulation for at least one cook to have possessed a current ServSafe certificate had not been followed. Interview on 2/3/16 at 10:15 a.m. by phone with the consultant registered dietitian revealed she: *Had started at the facility on 12/14/15. *Had been aware the dietary manager and at least one cook needed to have had a current ServSafe certificate. *Confirmed there needed to have been at least one cook that needed to have a current ServSafe certificate.	S 296		