

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

ORIGINAL

PRINTED: 01/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501
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F 000	INITIAL COMMENTS Surveyor: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/16/13 through 12/18/13. Golden LivingCenter - Pierre was found not in compliance with the following requirements: F248, F253, F371, and F514.	F 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on record review and interview, the provider failed to ensure an effective one-to-one activities program had been developed, implemented, and documented for one of one sampled resident (1) identified for a one-to-one activities program. Findings include: 1. Review of resident 1's 7/19/13 care plan revealed no one-to-one activities had been addressed as a focus area with measurable goals and interventions. Review of resident 1's October, November, and December 2013 individual programming form revealed: *She had received fifteen to twenty minutes of	F 248	F248 1. All residents who require one to one activities are at risk. The plan of care for resident 1 has been updated to include examples of one to one activities. Documentation is present for one to one activities every day. 2. The Director of Nursing Services (DNS) will in-service Activities Coordinator and nursing assistants no later	2/6/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jani Paske</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>1/17/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	Continued From page 1 one-to-one activity a day. *No one-to-one activities had been documented as completed on the weekends on that form. Interview on 12/18/13 at 2:45 p.m. with the activities director revealed: *One-to-one activities should have been care planned. *One-to-one activities should have been offered and documented if completed on the weekends. Interview on 12/18/13 at 2:35 p.m. with the director of nursing revealed: *She agreed one-to-one activities should have been care planned. *She would have expected staff members to have been offering one-to-one activities on the weekends. *She agreed there would be no way to know if one-to-one activities had been offered or completed if they had not been documented. Review of the provider's one-to-one Activity Intervention Guidelines revealed "A 1-1 (one-to-one) Activity intervention is a designated part of a resident's care, and is established within the care plan context to answer a personal need. To be a 1-1 Activity intervention means that the contact with the resident will include a process of meaningful activity."	F 248	than February 1, 2014 on ensuring the plan of care addresses examples of one to one activities and one to one activities occur with daily documentation present to include weekends. 3. The DNS or designee will audit residents that are on a one to one activity program to review their care plans and documentation logs weekly X 4 and then monthly x 3 to ensure one to one activities are care planned to include examples and daily documentation is completed. Results of audits will be reported by the DNS and discussed at monthly Quality Assurance and Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit. 4. February 6, 2014		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	F253 1. All residents are at risk. Corrections to the environment are as follows: Repaired the wooden surface on the glider rocker. Repaired the wooden surfaces on the	2/6/14	

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F 253	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, record review, and policy review, the provider failed to:</p> <ul style="list-style-type: none"> *Maintain a cleanable surface for wooden furniture on: <ul style="list-style-type: none"> -The arms of a rocker/glider chair in the ACU unit. -Two of two wooden dining tables in the Alzheimer's Care Unit (ACU). -Counter edges in the dining area of the ACU unit. -Two of two wooden dining tables in the social area in the west wing. -Multiple bedside stands, and dressers in randomly observed resident rooms in the facility. *Maintain a cleanable surface on one of two hair dryer hoods in the beauty shop. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Random observations from 12/16/13 at 2:30 p.m. through 12/18/13 at 4:30 p.m. revealed: <ul style="list-style-type: none"> *A brown rocker/glider chair in the sitting area of the ACU unit (photo 2). The finish on the wooden arms had been worn off causing the bare wood to be exposed. *Two wooden dining room tables located in the ACU unit had bare wood exposed. The finish on the edges of those tables had been worn the most. *There had been two wooden dining room tables located in the west wing social area with bare wood exposed (photo 4). The finish on the edges of those tables had been worn the most. *The finish on the wooden counter edges in the dining area of the ACU unit was worn off exposing the bare wood (photo 1). *Multiple bedside tables and dressers throughout the facility had areas of exposed wood due to 	F 253	<p>dining tables in the ACU and Social Area. Repaired the counter edges in the dining area of the ACU. Hair Dryer was discarded. The plan for the nightstands and dressers is to repair 6- 8 per week until all necessary nightstands and dressers have a cleanable surface. The Maintenance Supervisor is responsible to complete these repairs. This task was initiated 1/16/14 and will continue until finished.</p> <p>2. Maintenance Supervisor will be in-serviced by the Executive Director (ED) no later than February 1, 2014 on maintaining cleanable surfaces for wooden furniture.</p> <p>3. The ED or designee will conduct environmental audits weekly X 4, then monthly X 3 to ensure all wooden surfaces are maintained as cleanable surfaces. Results of audits will be reported by the ED and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. February 6, 2014</p>	

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F 253	<p>Continued From page 3</p> <p>wear (photo 3). Some of the rooms those had been located in were resident rooms 101, 106, 107, 111, 112, 113, 114, 205, 207, 208, 215, 218, and 221. The exposed wood caused those surfaces to be uncleanable.</p> <p>Interview on 12/18/13 at 9:00 a.m. with the maintenance supervisor confirmed: *The arms on the rocker/glider needed to be sealed. *He had worked on the table edges about a month ago. *He had used Old English Scratch Cover and Murphy Oil Soap Clean and Shine to repair the exposed areas. *He had believed the Murphy Oil Soap Clean and Shine had sealed the wood. *He had blamed the cleaners used on the tables as the cause of the finish being removed and exposing the bare wood.</p> <p>Review of the manufacturer's bottle recommendation use for Murphy's Oil Soap Clean and Shine revealed it was to have been used to clean wood surfaces. It was not to have been used on unfinished or unsealed wood. It was a cleaner not a sealant.</p> <p>Review of the quarterly preventative maintenance form dated 11/18/13 revealed the condition of the dining room tables, bedside tables, dressers, and rocker/glider had not been addressed.</p> <p>Interview on 12/18/13 at 2:15 p.m. with the administrator confirmed: *The replacement for the dining room tables, bedside tables, and dressers had been proposed for the 2014 budget. *That request had not been approved at this time.</p>	F 253			

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F 253	Continued From page 4 *She had not known if it would be approved or not. *She agreed the bare wood had not been cleanable. 2. Observation on 12/18/13 at 3:15 p.m. revealed a hair dryer hood in the beauty shop had tape around the edge, and it had been cracked. Interview on 12/18/13 with the director of nursing at that same time confirmed it had not been cleanable. She then removed it from the beauty shop.	F 253			
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: 32573 Preceptor: 26632 Based on observation, testing, interview, and policy review, the provider failed to ensure: *Food stored in the refrigerator had been labeled and dated.	F 371	F371 1. All residents are at risk. Corrections to the dietary service environment are as follows: Food stored in the refrigerator has been labeled and dated. Proper cooling techniques are being used for left-over food. Proper holding temperatures are being maintained for cold foods. Thermometers for testing food temperatures have been calibrated. Mighty shakes are being dated after thawing. The utensil drawers have been cleaned. The convection oven has been cleaned. The area above the steam table has been cleaned. The wall board has been repaired. The kitchen has been cleaned and is maintained in a sanitary manner. Dietary Services is being reviewed through the QAPI process. The facility has developed a plan to replace the entire kitchen, dish room and storage	2/6/14	

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F 371	<p>Continued From page 5</p> <p>*Proper cooling techniques had been used for left-over food.</p> <p>*Proper holding temperatures had been maintained for cold foods.</p> <p>*Thermometers for testing food temperatures had been calibrated.</p> <p>*Mighty shakes had been dated after thawing.</p> <p>*The kitchen had been maintained in a sanitary manner.</p> <p>*Quality assurance (QA) processes related to dietary services had been performed.</p> <p>Findings include:</p> <p>1. Observation in the kitchen on 12/16/13 at 2:10 p.m. revealed two covered containers in the refrigerator with pears in one and sauerkraut in the other. There were no labels on those containers stating what was in them or when they had been placed in the refrigerator.</p> <p>Interview with the dietary manager (DM) at that time revealed he had not been aware those containers had not been labeled or dated.</p> <p>Review of the provider's 2011 Storing Prepared Foods policy revealed items (extra portions) were to have been labeled with the content's name and the use-by date.</p> <p>2. Observation in the kitchen on 12/16/13 at 2:10 p.m. revealed two containers in the refrigerator with scalloped potatoes in one and sliced ham in the other.</p> <p>Interview with the DM at that time revealed the above were leftovers from the lunch meal. They had been placed in the refrigerator at 12:30 p.m. He was aware of the correct requirements for cooling foods.</p>	F 371	<p>room floor. On 1/14/14, a contractor assessed the kitchen flooring to establish a bid for the facility. The Department of Health (DOH) will be updated periodically on the progression of the floor replacement. Executive Director will notify the DOH with the initial start date and forward on-going communication as it is received.</p> <p>2. Dietary Service Manager (DSM) and ED will in-service the dietary staff on proper storing, preparing, distributing and serving food under sanitary conditions. In-service will be completed no later than February 1, 2014.</p> <p>3. The ED or designee will conduct audits of dietary services weekly X 4, then monthly X 3 to ensure proper storing, preparing, distributing and serving food under sanitary conditions. Results of audits will be reported by the ED or designee and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. February 6, 2014</p>	

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F 371	<p>Continued From page 6</p> <p>Surveyor 32573 checked the temperatures of the foods at 2:45 p.m. and the scalloped potatoes were 107.6 degrees Fahrenheit (F). The ham slices were 86 degrees F.</p> <p>Review of the Food and Drug Administration (FDA) Food Code 2013 Chapter 3-501.14 Cooling revealed: "(A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 135°F to 70°F; P and (2) Within a total of 6 hours from 135°F to 41°F or less."</p> <p>3. Observation and temperature testing on 12/16/13 at 5:10 p.m. during supper preparation revealed the: *Potato salad temperature was 48.6 degrees F. *Pureed turkey salad temperature was 50.5 degrees F.</p> <p>Interview on 12/16/13 at 5:25 p.m. with cook F revealed she expected cold foods to be 49 degrees F at serving time.</p> <p>Interview at the same time with the DM revealed he expected cold foods to be served at 41 degrees F.</p> <p>3. Observation and temperature testing on 12/16/13 at 6:10 p.m. immediately before supper service revealed the: *Pureed turkey salad temperature was 46.7 degrees F. *Turkey salad temperature was 44.6 degrees F. *Potato salad temperature was 43.1 degrees F. The DM then placed the items in the freezer to cool them to 41 degrees F before serving.</p>	F 371			

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F 371	<p>Continued From page 7</p> <p>Interview on 12/16/13 at 6:35 p.m. with the DM revealed he would place the pans of food in the serving table, and then take the temperature. He stated everyone had a different process of how they checked food temperatures. He thought it would have been more accurate to wait until the food was in the serving table.</p> <p>Surveyor 26632 On 12/16/13 at 5:40 p.m. the temperature of the foods that had been brought to the ACU were tested. The temperatures of those foods were: *Turkey salad temperature was 44.9 degrees F. *Potato salad was 49.5 degrees F.</p> <p>Interview with the director of the ACU at the above time revealed: *Staff from the ACU served the food that came from the kitchen for all meals. *No food temperatures had been taken before the food was served. *The kitchen staff obtained food temperatures before bringing the food down.</p> <p>Surveyor 32573 4. Observation and temperature testing on 12/17/13 at 5:20 p.m. of the food that was to be brought to the Alzheimer's Care Unit (ACU) dining room revealed the pureed bean salad temperature was 40.6 degrees F.</p> <p>Surveyor: 26632 On 12/17/13 at 5:40 p.m. the temperature of the pureed bean salad when it arrived in the ACU was 48.2 degrees F.</p> <p>Review of the Food and Drug Administration Food Code 2013, Chapter 3-501.16</p>	F 371		

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F 371	<p>Continued From page 8</p> <p>Time/Temperature Control for Safety Food, Hot and Cold Holding revealed:</p> <p>(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:</p> <p>(1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or</p> <p>(2) At 5°C (41°F) or less. P</p> <p>5. Observation on 12/16/13 at 2:10 p.m. revealed seven Mighty Shakes in the kitchen refrigerator. Those shakes were thawed. There was no date on the containers that indicated when they should have been used by. Review of the label of the Mighty Shakes revealed they were to have been used within fourteen days after having been thawed.</p> <p>Interview at the above time with the DM revealed he was aware the Mighty Shakes were to have been dated and used before fourteen days after they had been thawed.</p> <p>Observation on 12/18/13 at 1:30 p.m. of the medication room revealed seventeen thawed and undated Mighty Shakes.</p> <p>Interview at that time with the DM revealed the dietary department supplied the Mighty Shakes for the nursing department. He was not aware they had not been dated when thawed.</p> <p>Surveyor: 26632</p>	F 371		
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F 371	<p>Continued From page 9</p> <p>B. Based on observation, interview, and policy review, the provider failed to ensure the kitchen had been maintained in a sanitary manner for:</p> <ul style="list-style-type: none"> *The entire kitchen, dish room, and storage room floors. *Two of two utensil drawers. *One of one convection oven. *The area above the steam table. *The wallboard by the meat slicer. <p>Findings include:</p> <p>1. Observation from 12/16/13 at 2:10 p.m. through 12/17/13 at 3:30 p.m. revealed:</p> <ul style="list-style-type: none"> *The floors of the main kitchen, dish room, and storage room had broken and missing tiles. *There was a moderate build-up of greasy food debris and dirt in the broken and missing tiles and along the baseboard under the three compartment sink. *The inside of the two utensil drawers had a build-up of food particles. The drawer pulls had food debris that could be scraped off with a fingernail. *The area around the controls and the hinges of the convection oven had a moderate build-up of food debris. *The back of the convection oven by the toaster had visible food debris and lint present. *The area above the serving window had visible lint hanging down. Also the top of the fire suppression tank had visible lint. That suppression tank was located above and to the left of the steam table. *The wallboard by the meat slicer had a twelve inch by two inch piece missing. That created an uncleanable surface. <p>Interview on 12/17/13 at 4:00 p.m. with the dietary manager revealed he confirmed the above</p>	F 371			

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F 371	Continued From page 10 findings. He stated the kitchen needed a thorough cleaning. He also stated the floor needed to be replaced and was on the list of items that was going to be submitted for the capital budget. He was not aware when those items had been submitted. He stated he had cleaning schedules in place but did not review them nor the cleaning results. Review the provider's undated Daily Cleaning Schedule revealed the gas range, microwave, steam table, toasters, steamer, food processor, convection oven, work tables, pot and pan sink, kitchen floors and mats, dry store room, and the trash can containers were to have been cleansed twice daily in the morning and evening. He also had a cleaning schedule for the coffee makers, coffee dispensers, dish machine, work tables, doors, and shelves, eye wash basin, floors, floor mats, dining room carts, and the mop heads. Those items were to have been cleaned twice daily in the morning and evening.	F 371		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F514 1. All residents are at risk. No corrective action can be taken for resident 5, as she has passed away. Resident 9 has documentation present to support repositioning. 2. The DNS will in-service nurses & nursing assistants on ensuring that documentation is present to support that repositioning has occurred. In-service will be completed no later than February 1, 2014.	2/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2013
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F 514	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, record review, and interview, the provider failed to ensure documentation was present for the repositioning of two of two residents (5 and 9). Findings include:</p> <p>1. Observation on 12/17/13 from 7:10 a.m. through 4:30 p.m. of residents 5 and 9 revealed: *7:10 a.m. both residents were in their beds. Resident 9 was lying on her back and resident 5 was on her left side with her legs hanging partially out of the bed. *8:05 a.m. both residents 5 and 9 remained as above. *8:10 a.m. certified nursing assistant (CNA) G assisted resident 5 to place her legs back into bed. *8:20 a.m. CNA G and CNA H assisted resident 5 onto her back and moved her up in the bed to feed her breakfast. Resident 9 remained lying on her back. *9:30 a.m. both residents 5 and 9 remained lying on their backs. *10:10 a.m. both residents 5 and 9 remained lying on their backs. *11:15 a.m. both residents 5 and 9 remained lying on their backs. *12:45 p.m. resident 5 was eating lunch with assistance from CNA H, and the head of her bed was raised. Resident 9 was eating lunch independently, and the head of her bed was raised. *1:00 p.m. CNAs G and H assisted resident 5 with personal care. She was repositioned again</p>	F 514	<p>3. The DNS or designee will complete audits weekly x 4 and then monthly x 3 to ensure that documentation is present to support that repositioning has occurred. Results of the audits will be reported by the DNS and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. February 6, 2014</p>		

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

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OMB NO. 0938-0391

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F 514	<p>Continued From page 12</p> <p>on her back.</p> <p>*2:45 p.m. both residents 5 and 9 remained lying on their backs.</p> <p>*4:30 p.m. both residents 5 and 9 were positioned on their left sides.</p> <p>Review of resident 5's 10/22/12 care plan revealed she was at risk for pressure ulcers. She had the intervention of being repositioned at least every two hours.</p> <p>Review of resident 9's updated 12/9/13 care plan revealed she was at risk for pressure ulcers. She had the intervention to ensure she was repositioned at least every two hours and as indicated.</p> <p>Review of resident 5 and 9's interdisciplinary notes revealed no documentation of how often they had been repositioned.</p> <p>Interview on 12/18/13 at 2:00 p.m. with the director of nursing and CNAs G and H revealed: *They stated they had repositioned those residents every two hours. *They did not document when residents were repositioned. *There was no policy or procedure for the documentation of repositioning. *Resident 9 would frequently refuse to be repositioned.</p> <p>Review of the provider's revised 2013 Skin Integrity Guideline under the documentation and care interventions for skin integrity headline revealed "Initiate positioning schedule to meet individual resident needs and minimize concentrated pressure to skin."</p>	F 514			

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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 12/17/13. The 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 K029 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance. K029 1. All residents are at risk. The openings around the pipe penetrations in the boiler room have been sealed. Door closers have been installed on the fire sprinkler room and housekeeping storage room doors.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 A. Based on observation and interview, the provider failed to maintain proper separation of hazardous areas for the boiler room. The upper west wall had a six inch by six inch unsealed	K 029		2/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dawn Raske</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>1/17/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 029	<p>Continued From page 1</p> <p>opening around three pipe penetrations. Findings include:</p> <p>1. Observation at 1:45 p.m. on 12/17/13 revealed the boiler room had a six inch by six inch unsealed penetration around three pipes in the upper west wall. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the openings had been sealed in the wall on the opposite side (janitor's closet), but the boiler room side must have been forgotten.</p> <p>B. Based on observation and interview, the provider failed to maintain proper separation of hazardous areas for the fire sprinkler riser room and the housekeeping storage room. The rooms were being used for combustible storage. The corridor doors were not fire-rated as required for a hazardous room and were not equipped with closers. Findings include:</p> <p>1. Observation at 1:30 p.m. on 12/17/13 revealed the fire sprinkler riser room was approximately 115 square feet in area (8.5 feet x 13.5 feet) and was being used for the storage of copius amounts of combustible material. There were six boxes of Envision brand two ply embossed white bath tissue and seven cases of Acclaim brand white multifold towels stored in the room. The corridor door was an unrated solid bonded wood core door that was also not equipped with a closer.</p> <p>2. Observation at 1:45 p.m on 12/17/13 revealed the housekeeping supply room was approximately 75 square feet in area (5.75 feet x 13.5 feet) and was being used for storage of copius quantities of combustible material. There</p>	K 029	<p>2. ED will in-service the Maintenance Supervisor to monitor any closets that are used for storage to ensure they have the proper door closers installed. In-service will be completed no later than February 1, 2014.</p> <p>3. The ED or designee will complete audits weekly X 4 then monthly X 3 to ensure all closets that are used for storage have the proper door or closure on them. Results of the audits will be discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. February 6, 2014</p>	
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K 029	Continued From page 2 were ten cases of National brand can liners, one case of Acclaim brand white multifold towels, and two cases of Envision brand two ply embossed white bath tissue stored in the room. The corridor door was an unrated solid bonded wood core door that was also not equipped with a closer. Interview with the maintenance supervisor at the time of the observations confirmed those findings. Interview with the administrator at 5:00 p.m. on 12/17/13 revealed the two rooms were being used for combustible storage because the storage items would be close to the resident areas for staff.	K 029		
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 conduct the required inspection and cleaning of the kitchen range exhaust ductwork. Inspections/cleaning of the range hood exhaust ductwork must be conducted no less than annually (more frequently if needed based on findings). There was no documentation indicating the exhaust system had been inspected/cleaned since the previous survey dated 1/08/13. Findings include: 1. Document review of the kitchen hood system inspections revealed there was no documentation indicating a completion for inspection and cleaning of the exhaust ductwork for the kitchen	K 069	<p>K069</p> <p>1. All residents are at risk. The kitchen range exhaust ductwork has been inspected and cleaned.</p> <p>2. The ED will in-service the Maintenance Supervisor on the requirement of ensuring the kitchen range exhaust ductwork is inspected and cleaned at least annually. In-service will be completed no later than February 1, 2014.</p> <p>3. The Maintenance Director will monitor monthly after inspection is completed to ensure the kitchen range hood exhaust ductwork is clean. Results of the audits will be discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. February 6, 2014</p>	2/6/14

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K 069	Continued From page 3 range hood since the previous survey dated 1/08/13. Interview with the maintenance supervisor revealed a vendor had been contracted in 2013 to clean the ductwork. The vendor could not finish the job due to the roof ventilator being rigidly mounted. He further stated the ventilator had subsequently had a hinge installed to allow access to the ducting, but the contractor had not been back to complete the cleaning/inspection.	K 069			

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 000	Initial Comments Addendums noted with an asterisk per 1/23/14 telephone to facility administrator. NS/S000H/JJ Addendums noted with two asterisks per 1/27/14 telephone to facility administrator. CH/S000H/JJ Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/16/13 through 12/18/13. Golden LivingCenter - Pierre was found not in compliance with the following requirements: S121, S206, S296, and S322.	S 000	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
S 121	44:04:02:02 Sanitation The facility must be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases to 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 Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain a clean work environment in the kitchen and pantry areas. Findings include: 1. Observation beginning at 2:00 p.m. on 12/17/13 revealed the following unsanitary conditions in the kitchen and pantry: a) There was lint build-up on the grease filters in the kitchen range hood. b) There was lint build-up on the top front of the convection oven. c) There was lint build-up on the end of the surface mounted fluorescent overhead light fixture cover by the range. d) There was dust and lint in the ductwork grilles	S 121		S121 1. All residents are at risk. Corrections to the kitchen environment are as follows: The kitchen range hood and the top front of the convection oven have been cleaned and are free of lint build up. The overhead light fixture by the range has been cleaned and is free of lint build up.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jull Rosta TITLE: Executive Director (X6) DATE: 1/17/14

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S 121	Continued From Page 1 overhead in the kitchen and the pantry entrance. e) There were unsealed openings around conduit penetrations of the ceiling in the pantry. Interview with the administrator at 4:45 p.m. revealed she was unaware of all of the unsanitary conditions.	S 121	All ductwork in the kitchen and pantry have been cleaned. The openings around the conduit penetrations of the ceiling in the pantry have been sealed. The facility maintains a clean work environment in the kitchen and pantry areas.	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs. This Rule is not met as evidenced by: Surveyor: 32333	S 206	2. The ED will in-service the Dietary Services Manager (DSM), Maintenance Supervisor, and all dietary staff on ensuring that a clean work environment is maintained in the kitchen and pantry areas. In-service will be completed no later than February 1, 2014. 3. The ED or designee will complete ^{** preventive maintenance} audits [redacted] monthly to ^{CH/SOOTH/JJ} ensure that a clean work environment is maintained in the kitchen and pantry areas. Results of the audits will be reported by the ED and discussed at monthly Quality Assurance and Process Improvement (QAPI) for further review and recommendations and/or continuation/discontinuation of audits. 4. February 6, 2014 S206 1. All residents are at risk. All new employees receive a formal orientation program. * Employees A, B, C, D, and E have all completed the formal orientation program. <i>NS/SOOTH/JJ</i>	<i>2/6/14</i>

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S 206	Continued From Page 2 Based on record review and interview, the provider failed to ensure five of five sampled staff members (A, B, C, D, and E) had received a formal orientation program. Findings include: 1. Review on 12/18/13 of employee files (A, B, C, D, and E) hired within the previous six months revealed no formal orientation had been completed to include: *Proper use of restraints. *Patient and resident rights. *Incidents and diseases subject to mandatory reporting. *Care of residents with unique needs. *Dining assistance. Interview on 12/18/13 at 1:50 p.m. with the administrator and the director of clinical education revealed there had been no documentation the above listed employees had received the above listed formal orientation.	S 206	2. The ED will in-service the Director of Clinical Education (DCE) on ensuring that all new employees receive education to include: proper use of restraints, incidents and diseases subject to mandatory reporting, care of residents with unique needs and dining assistance. Resident rights are included in our orientation program. In-service will be completed no later than February 1, 2014. 3. The ED or designee will complete audits weekly x 4 and monthly x 3 to ensure that all new hires receive a formal orientation program. 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. February 6, 2014	
S 296	44:04:07:07 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 the Dietary Managers Association, must 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 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 Dietary Managers Association, or successfully completed equivalent training as determined by the Health Department. The dietetic manager	S 296	S296 1. All residents are at risk. The DSM provides all dietary staff with ongoing education to ensure food is served and stored at appropriate temperatures. 2. The DSM has reviewed his job description. The ED has provided education to the DSM on the requirement to provide education to the dietary staff on the required proper temperatures of food for storage and for serving. In-service will be completed no later than February 1, 2014.	2/6/14

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S 296	Continued From Page 3 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 must approve all menus, assess the nutritional status of...residents with problems identified in the 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 must be on duty daily over a period of 12 or more hours in nursing facilities... This Rule is not met as evidenced by: Surveyor: 26632 Based on observation, testing, and interview, the provider failed to ensure the dietary manager (DM) had provided all dietary staff with ongoing education to ensure food was served and stored at the appropriate temperatures. Findings include: 1. Observation in the kitchen on 12/16/13 at 2:10 p.m. revealed two containers in the refrigerator with scalloped potatoes in one and sliced ham in the other. Interview with the DM at that time revealed the above were leftovers from the lunch meal. They had been placed in the refrigerator at 12:30 p.m. He stated was aware of the correct requirements for cooling foods. This surveyor checked the temperatures of the foods on 12/16/13 at 2:45 p.m. the scalloped potatoes were 107.6 degrees Fahrenheit (F). The ham slices were 86 degrees F. Review of the Administrative Rules of South Dakota, Article 44:02 Food Service code, Section	S 296	3. The ED or designee will complete audits weekly x 4 and then monthly x 3 to ensure that the DSM has provided all dietary staff with ongoing education to ensure that food is served and stored at the appropriate temperatures. 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. February 6, 2014	

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/18/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501		
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S 296	Continued From Page 4 44:02:07:32 revealed: "Potentially hazardous food must be cooled: (a) From 140 degrees F to 70 degrees F within 2 hours." 2. Observation and temperature testing on 12/16/13 at 5:10 p.m. during supper preparation revealed the: *Potato salad temperature was 48.6 degrees F. *Pureed turkey salad temperature was 50.5 degrees F. Interview on 12/16/13 at 5:25 p.m. with cook F revealed she expected cold foods to be 49 degrees F at serving time. She was not aware of the required 41 degrees F for service of cold foods. Interview at the same time with the DM revealed he expected cold foods to be served at 41 degrees F. Observation and temperature testing on 12/16/13 at 6:10 p.m. immediately before supper service revealed the: *Pureed turkey salad temperature was 46.7 degrees F. *Turkey salad temperature was 44.6 degrees F. *Potato salad temperature was 43.1 degrees F. The DM then placed the items in the freezer to cool them to 41 degrees F before serving. Interview on 12/16/13 at 6:35 p.m. with the DM revealed he would place the pans of food in the serving table, and then take the temperature. He stated everyone had a different process of how they checked food temperatures. He thought it would have been more accurate to wait until the food was in the serving table. 3. On 12/16/13 at 5:40 p.m. the temperature of the foods were tested that had been brought	S 296		

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S 296	<p>Continued From Page 5</p> <p>down to the ACU. The temperatures of those foods were: *The turkey salad temperature was 44.9 degrees F. *The potato salad was 49.5 degrees F.</p> <p>Interview with the director of the ACU at the above time revealed: *Staff from the ACU served the food that came from the kitchen for all meals. *No temperatures of the food were taken before the food was served. *The kitchen staff obtained food temperatures before bringing the food down.</p> <p>4. Observation and temperature testing on 12/17/13 at 5:20 p.m. of the food that was to be brought to the Alzheimer's Care Unit (ACU) dining room revealed the pureed bean salad temperature was 40.6 degrees F.</p> <p>On 12/17/13 at 5:40 p.m. the temperature of the pureed bean salad was 48.2 degrees F. when it arrived in the ACU</p> <p>Review of the Administrative Rules of South Dakota, Article 44:02 Food Service Code, Section 44:02:07:35 revealed: "Potentially hazardous food must be kept at an internal temperature of 41 degrees F or below..... during display and service."</p> <p>5. Observation on 12/16/13 at 2:10 p.m. revealed seven Mighty Shakes in the kitchen refrigerator. Those shakes were thawed. There was no date on the containers that indicated when they should have been used by. Review of the label of the Mighty Shakes revealed they were to have been used within fourteen days after having been thawed.</p>	S 296		

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S 296	Continued From Page 6 Interview at the above time with the DM revealed he was aware the Mighty Shakes were to have been dated and used before fourteen days after they had been thawed. Observation on 12/18/13 at 1:30 p.m. of the medication room revealed seventeen thawed and undated Mighty Shakes. Interview at that time with the DM revealed the dietary department supplied the Mighty Shakes for the nursing department. He was not aware they had not been dated when thawed. 6. Interview on 12/18/13 at 1:45 p.m. with the DM revealed he had provided no education to the dietary staff on the required proper temperatures of food for storage and for serving.	S 296		
S 322	44:04:08:04.01 CONTROL AND ACCOUNTABILITY OF MEDICATIONS Written authorization by the attending physician must be secured for the release of any medication to a...resident upon discharge or transfer. The release of medication must be documented in the...resident's record, indicating quantity, drug name, and strength. This Rule is not met as evidenced by: Surveyor: 23059 Based on record review and interview, the provider failed to ensure a physician's order was received to release medications to one of one sampled resident (15) upon discharge. Findings	S 322	S322 1. All residents who discharge or transfer with medications are at risk. No corrective action can be taken for resident 15, as she has already transferred to another skilled nursing facility. A physician's order is obtained for release of medications to all residents upon discharge or transfer. 2. The DNS will in-service nurses on ensuring that a physician's order is obtained for release of medications to a resident upon discharge or transfer. In-service will be completed no later than February 1, 2014.	2/6/14

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S 322	Continued From Page 7 include: 1. Review of resident 15's closed record revealed she had been admitted on 5/14/13 and discharged to another nursing home on 11/14/13. At the time of discharge three medications had been sent with her. No physician's order was found in her record to release those medications. Interview on 12/18/13 at 9:15 a.m. with the director of nursing confirmed there was no order on resident 15's chart for discharge to another nursing home or release of those medications to her. She confirmed a physician's order should have been obtained prior to her discharge.	S 322	3. The DNS or designee will complete audits weekly x 4 and then monthly x 3 to ensure that a physician's order is obtained for release of medications to a resident upon discharge or transfer. Results of the audits will be reported by the DNS and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits. 4. February 6, 2014	