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

ORIGINAL

PRINTED: 11/19/2013
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
	435054		11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Addendums noted with an asterisk per 12/10/13 telephone to facility administrator. MP/SDDOH/MF Surveyor: 29162 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/4/13 through 11/7/13. Golden LivingCenter - Redfield was found not in compliance with the following requirements: F157, F176, F221, F241, F248, F253, F280, F281, F309, F312, F318, F323, F353, F371, F425, F431, F441, F490, F493, F514, and F520.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Rude
TITLE: ED
(X6) DATE: 12/4/13

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 157	Continued From page 1 regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to notify the physician and responsible party regarding: *Scratches, scabs, and scarring for one of two sampled residents (5) with a seat belt physical restraint. *Pain during one of one observed dressing change on resident (8). Findings include: 1. Review of resident 5's progress notes revealed: *10/20/13 "Resident has two scratches across right breasts approximately 2.5 to 3 centimeters (cm) and 1/2 cm wide both areas scabbed with no redness or signs of infection will continue to monitor." *10/21/13 "Scratches to right breast are without signs and symptoms of infection. Upon observation seat belt hits resident at breasts and noted that some staff members are putting belt on to tight." *10/28/13 "Does have scab and scarring under right breast from seatbelt rubbing." *11/4/13 "Resident has area on chest from rubbing of seatbelt on area." Review of resident 5's 5/31/13 physician's order	F 157	F 157 1. Resident #5's physician and responsible party were notified of the scratches, scabs and scarring on 11/25/13 by [redacted], DNS. Resident #5's physician and responsible party were notified to clarify the seatbelt physical restraint on 5/31/13 by [redacted], ACU Director. Resident #8's physician was notified of the resident's pain during the dressing change on 11/25/13 by [redacted], DNS. All residents have the potential to be affected. * mp/SDOH/MF * mp/SDOH/MF * mp/SDOH/MF 2. Licensed nursing staff will be educated on the Condition Change of the Resident and the Sterile Dressing Change procedure by the Director of Nursing Services by 12/27/13. * pain with treatments, + seat belt use. mp/SDOH/MF 3. The Director of Nursing Services (DNS) or designee will randomly audit 5 patients' medical record for proper notification of the physician and/or responsible party to ensure proper and timely notification occurs with any changes weekly x 4 and monthly x 3 to ensure compliance. The DNS or designee will randomly audit 5 residents' dressing changes to ensure the dressing change, sterile procedure is followed weekly x 4 and monthly x 3 to ensure compliance. The DNS will report audit results to the monthly Quality Assurance Performance Improvement (QAPI) Committee for further review and recommendations.	4. 12/27/13

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F 157	Continued From page 2 and informed consent for physical restraints revealed a seatbelt physical restraint was recommended for the following reason "When interventions of toileting, offering food or snack, one to one visits, evaluating of pain are not effective for restlessness related to a diagnosis of dementia and unable to understand physical deficits and safety issues as needed (PRN)." Review of resident 5's September 2013 current active physician's orders revealed there had not been an order for a seatbelt physical restraint. Review of resident 5's October and November 2013 treatment administration record revealed: *Resident may have PRN seatbelt when interventions of toileting, offering food/snack, one-to-one visiting, evaluation of pain were non-effective for restlessness related to a diagnosis of dementia and unable to understand physical deficits and safety issues as needed. *The above treatment had not been signed off as being used in October or November 2013. Review of resident 5's entire medical record revealed: *The physician and responsible party had not been notified of resident 5's scratches or of the scabbing. *The physician and responsible party had not been notified to clarify the seatbelt physical restraint had not been on the resident's current active orders. 2. Observation and interview on 11/6/13 at 10:30 a.m. with licensed practical nurse (LPN) F while performing a dressing change on resident 8 revealed: *The resident had yelled "Ouch" twice during the	F 157		

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F 157	Continued From page 3 procedure. *LPN F said resident 8 had not usually complained of pain during the dressing change. Review of resident 8's entire medical record revealed: *She had been non-interviewable related to her diagnosis of Alzheimer's. *The physician had not been notified regarding her pain during her dressing change. *No documentation of the dressing change or the resident's pain had been documented. 3. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed she would have expected the physician and responsible party to have been notified regarding resident 5's scratches, scabs, and scarring. She also would have expected the physician and responsible party to have been notified regarding resident 8's complaints of pain during her dressing change. Review of the provider's undated Condition Change of the Resident procedure revealed: *A condition change in the resident should have been recorded and reported to the attending physician so proper treatment could have been implemented. *Documentation should have included notification of the physician and notification of the resident's responsible party. Review of the provider's undated Dressing Change, Sterile procedure revealed "Any pain; report to physician."	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE	F 176		

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F 176	Continued From page 4 An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, interview, record review, and policy review, the provider failed to ensure medications were properly administered to one of one randomly observed resident (16). Findings include: 1. Observation on 11/5/13 at 5:50 p.m. revealed resident 16 had been sitting at the dining room table waiting for the evening meal. *Unlicensed assistive personnel (UAP) C had set a medication cup with a white pill in it in front of her on the table. The resident acknowledged the medication being sat in front of her with a nod. The UAP then went to the medication cart, locked it, and pushed it out of the dining room. She had not returned to the dining room during that meal time. UAP C did not observe the resident taking the medication. 2. Review of resident 16's medical record revealed: *She had been admitted on 1/23/13. *She had the following diagnoses: -Renal (kidney) failure. -Pneumonia. -Generalized pain. -Chronic airway obstruction (COPD). -Hypertension (high blood pressure). -Transient cerebral ischemia (TIA). -Atrial fibrillation (irregular heart beat).	F 176	F176 1. Unlicensed assistive personnel (UAP) C was verbally educated by DNS, additionally UAP was educated on 11/25/13 regarding the requirement to monitor resident until medications have been consumed. The care plan for resident 16 was updated on 11/25/13 to reflect residents current ability to self administer medications. All residents have the potential to be affected. * MP\SDDOH\MF 2. Education will be provided to staff responsible for administration of medications and the care plan team by 12/5/13 regarding the policy and procedure for self administration of medications. 3. DNS or designee will audit 5 residents medication pass, physicians orders and care plan week x 4, then monthly x 3. Results of these audits will be presented by the DNS to the monthly QAPI Committee for review and recommendation. * Resident population was evaluated and no other residents were identified at that time to have a change in their self-administration orders. MP\SDDOH\MF	4. 12/27/2013

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F 176	Continued From page 5 -Edema (excess fluid). *Her revised 7/28/13 care plan had a focus area of "May self-administer medications and neb (nebulizer) tx (treatment) after set-up by nurse/med aide (UAP)." *The goal of that focus was "The patient will safely administer medications." *The interventions for that focus had been: -"Confirm and document the medications administered." -"Nursing to ensure all medications and neb tx are taken by resident." -"Periodic safety assessment/evaluation of patient's ability to dispense medications." *There had not been an order from the physician for self-administration of medication after set-up. Interview on 11/6/13 at 1:25 p.m. with registered nurse (RN) D and licensed practical nurse (LPN) E confirmed resident 16 had no longer been able to self-administer medications. "She had been dropping the medications on the floor." Interview on 11/6/13 at 2:00 p.m. with UAP C confirmed she had not been aware resident 16 had no longer been appropriate for self-administration of medications. Interview on 11/7/13 at 8:30 a.m. with the director of nursing (DON) confirmed she would have expected the medications to have been monitored until consumed. She confirmed resident 16 did not have an order to self-administer medications. She confirmed she would have expected the care plan to have reflected the current status of the resident. 4. Review of the provider's October 2007 Medication Administration Self-Administration by	F 176		

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F 176	Continued From page 6 Resident policy revealed "Residents who desire to self-administer medications are permitted to do so with a prescriber's order and if the nursing care center's interdisciplinary team has determined that the practice would be safe." Review of the undated Long-Term Care Facilities Resident's Bill of Rights that was included in all resident's admission packet revealed "A resident may self-administer drugs if the physician, RN, pharmacist, and social worker or designee have determined the practice to be safe."	F 176		
F 221 SS=G	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (5 and 8) with a seat belt had remained free from physical restraints. Findings include: 1. Review of resident 5's September 2013 current active physician's orders revealed she had no order for a seat belt physical restraint. Review of resident 5's 5/31/13 physician's order and informed consent for physical restraints revealed a seat belt physical restraint had been recommended for the following reason "When	F 221	F 221 1. Skin concerns for resident 5 have healed. DNS contacted resident 5 family and physician on 11/25/13 to review the use of the seatbelt and discuss history of skin concerns related to the use of the seatbelt. Resident 5 does have an order for a lap belt that was written on 5/31/13. The order report that was printed and signed by physician did not include physician's orders for lap belt. A report including this order was printed and signed by physician on 11/27/13.	

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F 221	Continued From page 7 interventions of toileting, offering food or snack, one-to-one visits, evaluating of pain are not effective for restlessness related to a diagnosis of dementia and unable to understand physical deficits and safety issues as needed (PRN)." Review of resident 5's 7/15/13 care plan revealed an intervention for as needed seat belt physical restraint to be utilized when interventions of toileting, offering food or snack, one to one visits, evaluating of pain were not effective for restlessness related to a diagnosis of dementia and unable to understand physical deficits and safety issues as PRN. Review of resident 5's progress notes revealed: *10/20/13 "Resident has two scratches across right breasts approximately 2.5 to 3 centimeters (cm) and 1/2 cm wide both areas scabbed with no redness or signs of infection will continue to monitor." *10/21/13 "Scratches to right breast are without signs and symptoms of infection. Upon observation seat belt hits resident at breasts and noted that some staff members are putting belt on to tight." *10/28/13 "Does have scab and scarring under right breast from seat belt rubbing." *11/4/13 "Resident has area on chest from rubbing of seatbelt on area." Review of resident 5's October and November 2013 treatment administration record (TAR) revealed: *Resident may have PRN seatbelt when interventions of toileting, offering food/snack, one-to-one visiting, evaluation of pain were non-effective for restlessness related to a diagnosis of dementia and unable to understand	F 221	On 11/7/13 maintenance personnel lowered the seatbelt on the wheelchair for resident 5 to a more appropriate height. Nursing assistants will be educated by 12/5/13 regarding the need to report to nurse when the use of a restraint is needed. Nursing assistants will be educated by 12/5/13 regarding safe application of restraints. Nursing staff will be educated by 12/5/13 regarding the need to document the use of a restraint on the medication or treatment administration record (MAR or TAR). Nursing staff will be educated by 12/5/13 regarding the need to document behaviors and interventions occurring prior to the use of a restraint. All residents who use restraints have potential to be affected. 2. On 11/26/13 DNS and care plan team reviewed the policy and procedure about restraint use, no revisions were made. Staff will be provided directed in-service training by 12/5/13 regarding restraint use, including but not limited to definition of what constitutes a restraint, assessment of the use and appropriate involvement of physician and family, documentation of assessment and care plan for appropriate use and reassessment for continued need of a restraint, use of least restrictive device.	

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F 221	Continued From page 8 physical deficits and safety issues as needed. *The above treatment had not been signed off as having been used in October through 11/6/13. Interview on 11/6/13 at 9:45 a.m. with certified nursing assistant (CNA) M revealed: *She had used the seat belt physical restraint on resident 5 when the resident had been trying to transfer herself onto her bed. *She did not have to consult with the nurse before using the seat belt physical restraint. *She had not documented the use of the seat belt physical restraint, because she did not have anywhere to document it. Review of resident 5's entire medical record revealed the physician and responsible party had not been notified regarding her scratches, scabbing, and scarring related to the use of the seat belt physical restraint. 2. Observation on 11/6/13 at 2:15 p.m. of resident 8 in her wheelchair in the day room revealed she had a seat belt around her waist. Observation and interview on 11/6/13 at 2:15 p.m. in the advanced Alzheimer's care unit with CNA N and O revealed: *They had come on duty at 2:00 p.m. *They had not known who had put the seat belt on resident 8. *They had not noticed the seatbelt had been on resident 8. *Resident 8 had not been exhibiting any behaviors for the use of a seat belt physical restraint. *They had been able to utilize physical restraints without consulting a nurse.	F 221	*the mp/sd/dh/mf 3. DNS or designee will audit 2 residents who use restraints to ensure proper documentation and policy/procedure is being followed weekly x 4 then monthly x 3. Results of these audits will be presented by the DNS to the monthly QAPI Committee for review and recommendation.	4. 12/27/13

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F 221	Continued From page 9 Interview on 11/6/13 at 5:30 p.m. with LPN F revealed CNAs were able to put on a seat belt and lap buddy physical restraint without consulting with the nurse. Review of resident 8's 10/4/13 physician's orders revealed an order for "As needed (PRN) seat belt when interventions of toileting, offering food/snack, one to one visiting, evaluation of pain are non-effective for restlessness related to a diagnosis of Dementia and unable to understand physical deficits and safety issues as needed." Review of resident 8's November 2013 TAR revealed the above stated physician's order had not been signed off as having been used. Review of resident 8's entire medical record revealed no other documentation of the PRN seatbelt having been used. Interview on 11/6/13 at 2:00 p.m. with the Alzheimer's care director and the director of nursing revealed: *They would have expected the nurse to have assessed the need for the seat belt physical restraint before utilizing it. *CNAs were unable to assess the need for a seat belt physical restraint. *They would have expected the nurse to have signed off the use of the seat belt physical restraint on the TAR. *They would have expected nursing staff to have tried and documented other interventions before utilizing the seatbelt physical restraint. *They would have expected behaviors and interventions to have been documented in the resident's medical record.	F 221		

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F 221	Continued From page 10 Review of the provider's Restraint Evaluation and Utilization Guideline revealed: *"If a restraint is utilized to treat a resident's medical symptoms, to prevent injury and promote the highest practicable level of independence careful evaluation will precede this decision." *"A restraint will not be applied for the purposes of discipline or convenience or when not required to treat the resident's medical symptoms. The least restrictive device will be used." *"Restraint utilization should be considered only if and when other alternatives practices have been attempted and ruled ineffective." *"The center will obtain a physician order for the least restrictive device. The physician order must include: -The medical symptoms for which the device is to be used. -Type of device to be used. -When the restraint is to be used. -How long it should be applied." *"The physician order alone is not sufficient to warrant the use of the restraint."	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation and interview, the provider failed to ensure dignity and respect for one of three sampled residents (12) and three randomly	F 241	F 241 1. C.N.A. M, C.N.A. P, and Alzheimer's Care Director will be educated by the DNS or designee on dignity and respect of residents, personal grooming, ensuring assistance is available for each individual during meal time, and ensuring residents are appropriately dressed , clean and dry by 12/5/13.* All residents have the potential to be affected. *The residents identified were properly groomed & assisted at meal time immediately following notification. MPISDBOHIMF	

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F 241	Continued From page 11 observed residents (21, 23, and 26) in the advanced Alzheimer's care unit (AACU) was maintained. Findings include: 1. Observation on 11/5/13 from noon through 12:30 p.m. of the noon meal service revealed: *Resident 21 had no staff assistance during the meal service. *Resident 23 had food running down her chin. *Resident 26 had facial hair visible from across the room. Refer to [redacted], finding 1. F312 JD/SDDH/JJ 2. Observation on 11/6/13 at 5:35 p.m. of resident 12 revealed she had visibly wet pants. She had been helped to her seat at the dining room table. However she had not been helped to the toilet or had her pants changed before she had been seated at the dining room table. Refer [redacted], finding 2. F312 JD/SDDH/JJ 3. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed all residents should have been treated with dignity and respect.	F 241	2. All staff will be educated by 12/5/13 regarding the Policy and Procedure ensuring resident rights to dignity and respect including the following: what constitutes dignity and respect, personal grooming of residents, ensuring residents are appropriately dressed, clean and dry and ensuring assistance is available for each resident for dining and other needs by 12/5/13. The Administrator, DNS and Social Services reviewed as necessary the policy and procedure regarding resident rights to dignity and respect on 11/26/13, no revisions were made. 3. The DNS or designee will randomly audit: 5 residents to ensure assistance is available for each individual during meal time, that dignity is maintained during the meal service to include the absence any food on the resident's face or clothing, and for proper grooming to include any excess facial hair weekly x 4 and then monthly x 3 to ensure compliance. The DNS or designee will report audit results to the monthly QAPI Committee for further review and recommendations.	4. 12/27/13
F 248 SS=E	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 observation, interview, record review,	F 248		

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F 248	Continued From page 12 and policy review, the provider failed to: *Develop, implement, and maintain an effective activities program for all residents in one of one advanced Alzheimer's care unit (AACU). *Appropriately document attendance and participation in activities for one of two sampled residents (3) in the Alzheimer's care unit (ACU). Findings include: 1a. Observation on 11/6/13 at 2:15 p.m. through 2:30 p.m. in the AACU revealed: *Resident 8 had been in the day room with her seat belt physical restraint on. Refer to F221, finding 2. *Seven randomly observed residents had been sitting in recliners with their eyes closed in the day room. *Three randomly observed residents had been sitting in the dining room at tables with nothing to do. *One of the three randomly observed residents was pushing crumbs of food around on the table. Interview on 11/6/13 at 2:25 p.m. with certified nursing assistant (CNA) N revealed: *Three of the seven randomly observed residents who had been in recliners in the day room were not able to get out of the recliners on their own. *After lunch they toileted the residents, and then put them in a recliner or to bed until snack or supper time. b. Observation on 11/6/13 from 5:15 p.m. through 5:40 p.m. in AACU revealed: *Resident 20 had been sitting in a recliner with his foot rest up. *Resident 23 had been sitting in her wheelchair in her room groaning with her feet dangling. She was slumped over the left side of her wheelchair	F 248	F248 1. Daily recreation records for residents 3, 5, 8, 12, 20, 22, 23, 24 were reviewed and revised by Alzheimer's Care Director (ACD) to include individualized activity programming on 11/25/13. Care plans for residents 3, 5, 8, 12, 20, 22, 23, 24 were reviewed and revised by the care plan team including the ACD on 11/26/13 to include an individualized activity program plan. Resident 8 did have an activity care plan present in the care plan book dated 3/22/13, reviewed on 6/25/13, reviewed again on 9/17/13. CNA H was educated on 11/26/13 regarding procedure for appropriately documenting residents participation in activity. Please refer to F312 regarding resident 12 pants being wet and visibly soiled. Please refer to F318 regarding restorative programming. Please refer to F353 regarding staffing on the ACU and AACU. All residents who reside in the Alzheimer's Care Unit (ACU) and the Advanced Alzheimer's Care Unit (AACU) have potential to be affected.	

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F 248	Continued From page 13 arm. *Resident 24 was slumped over the right side of her wheelchair. *Resident 22 had been trying to get up out of her wheelchair and CNA O had put a lap buddy restraint on to her wheelchair. The CNA then went into the bathroom to assist another resident. *Resident 12's pants had been visibly soiled and wet. Refer to F312, finding 2. Interview on 11/6/13 at 5:15 p.m. with CNA N revealed: *Resident 20 had been sitting in a recliner in the day room since she had come in at 2:00 p.m. *No one-to-one activities had been offered that afternoon. *No group activities had been offered. c. Review of resident 5's November 2013 Daily Recreation Record revealed: *One-to-one activities had not been marked off as having been given. *Exercise, music, sensory, visiting, snack, baby therapy, and TV had been marked with an A (actively participated) from 11/1/13 through 11/5/13. Review of resident 5's 7/9/13 care plan revealed "If I become less involved in group activities, please do one to one activities with me that I'll enjoy. I enjoy visiting and holding hands." d. Review of resident 8's November 2013 Daily Recreation Record revealed: *One-to-one activities had not been marked off as given. *Music, current event, sensory, visiting, and snack had been marked with an A on 11/1/13	F 248	2. ACD and Activity Coordinator were educated on 11/26/13 regarding development, implementation and maintenance of activity programming on the ACU and the AACU. Staff will be educated by 12/5/13 regarding appropriate procedures for documenting attendance and participation in activities. On 11/26/13 Administrator and Activity Director reviewed the policy and procedure about provision of activities in the facility and job description of activity coordinator. No revisions were made. Staff will be provided directed in-service training by 12/5/13, training will include but not limited to definition of what constitutes and activity, sufficient staff for the provision of activity, appropriate education and resources available for the provision of activity, available activity for those residents with cognitive deficits. 3. Activity Director or designee will audit 3 activities and 5 resident daily recreation records and care plans to ensure activities and records are taking place and being recorded according to policy and procedure weekly x 4 then monthly x 3. Results of these audits will be presented by the Activity Director to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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F 248	Continued From page 14 through 11/5/13. *On 11/1/13 and 11/2/13 baby therapy had also been marked with an A. Review of resident 8's 3/22/13 care plan revealed activities had not been care planned. Refer to F280, finding 3. e. Review of the ACU and AACU Daily Recreation Record revealed: *It had been a generic form. *It was not individualized for each resident. Interview on 11/6/13 at 9:00 a.m. with the activity director revealed she had nothing to do with activities in the ACU or the AACU. Interview on 11/6/13 at 9:40 a.m. with the restorative nurse revealed: *She did not assess the need or discharge of restorative care for the residents in the AACU. *If a resident refused restorative care for one week she discharged them from the program. *She did not assess why the resident might have been refusing restorative care, she just relied on the CNAs to do that. *There was one restorative CNA. *She did not provide restorative care in the AACU. *The CNAs working in the AACU were responsible for doing restorative care for those residents. *Refer to F318, finding 1. Interview on 11/6/13 at 9:45 a.m. with CNA M who worked in the AACU revealed: *Two CNAs were scheduled from 6:00 a.m. through 10:00 p.m. daily in the AACU. *One CNA was scheduled from 10:00 p.m.	F 248		

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F 248	Continued From page 15 through 6:00 a.m. in the AACU and in the ACU. *Those CNAs had been responsible for all activities of daily living (ADL) including bathing/showering, dressing, grooming, feeding, as well as activities and the restorative program. Interview on 11/7/13 at 9:30 a.m. with the Alzheimer's care director revealed: *They did not have big group activities in the AACU. *She would have expected frequent one-to-one activities. *She would have expected dependent residents to have been repositioned every two to three hours. *She did believe activities should have been individualized. *She would have liked to have had more staff. Surveyor: 28057 2. Review of resident 3's 11/5/13 care plan revealed a focus that indicated the resident had needed some assistance to participate in activities of her choice. The goals were the resident would continue to participate as she tolerated and would participate as independently as possible. Interventions had been to assist her to activities, encourage her participation in the activity, and invite her to watch if not actively participating. It had also stated activities of interest had been Mass, rosary, special events, exercise group, Bible study, and bingo. Review of resident 3's November 2013 Daily Recreation Participation Record on 11/6/13 at 9:40 a.m. revealed documentation for 11/6/13. It had been documented she had participated in baking. The documentation showed the resident	F 248		

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F 248	Continued From page 16 had been actively participating in the baking. That documentation was prior to the baking activity observed below. It had not had staff initials as to who had documented the participation. Other activities in November the resident had been documented as having had attended exercise, sensory/relax, snacks/social, baby therapy, and baking. The activities listed in her care plan had not been documented and were not on the Daily Recreation Participation Record. Observation on 11/6/13 from 9:45 a.m. through 9:55 a.m. revealed resident 3 had been seated in her wheelchair in the dining area of the ACU. She was asleep. The ACU coordinator had provided a baking activity at that time. One resident helped mix the cake with a mixer. The rest of the residents sat in a circle around the kitchen area and watched. When the cake had been mixed the coordinator carried the pan around for the residents to look at before it had been put in the oven. She had awakened resident 3 who raised her head and looked at the cake and promptly went back to sleep. Her head was down, and her eyes closed again. She had not actively or passively participated in the activity. Interview on 11/7/13 at 9:35 a.m. with the ACU coordinator confirmed CNA H had documented the resident's participation before the activity had occurred. She agreed it had not been accurate and had not been the expected way to document activities. She further agreed the resident had not participated in the activity at all and had been asleep throughout the activity. Surveyor 32333 Review of the provider's 2009 Recreation	F 248		

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F 248	Continued From page 17 Services Guide revealed: *"Programming will be offered to all residents who are unable or choose not to attend group activities." *"Individual programming ensures that all residents who are unable to or choose not to participate in group programs have consistent, goal-oriented and individualized recreation opportunities." *"Structured individual interventions will be developed based on each resident's history and assessed needs and preferences." *"Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical, and cognitive functioning needs."	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on random observations, interview, and policy review, the provider failed to ensure housekeeping and maintenance services to the interior of the facility were maintained in a sanitary manner. Findings include: 1. On 11/6/13 at 8:30 a.m. an environmental walk-through tour with the temporary part-time maintenance supervisor (MS) from the another Golden Living Center revealed: a. Wood under the paper towel dispensers in	F 253	F253 1. 1a. The wood underneath the paper towel dispenser will be refinished with a cleanable surface by December 27, 2013 b. The chips corners by the sink in resident rooms 7, 9, 11, 20, will be repaired with joint compound and paint by December 27, 2013 c. The chipped wood surfaces on the cupboard doors, under the sink, in resident rooms 7, 9, 10, 11, will be smoothed by sanding and refinishing by December 27, 2013 d. The wet wood, under the sink in resident rooms 7, 13, 15, will be dried and repairs completed by December 27, 2013 e. The laminate on the resident dressers, resident rooms 8, 13, [redacted], will be repaired sanding, varnishing and laminating if needed or removed from service by December 27, 2013 f. Caulking around the toilets in resident rooms 9, 10, 11, 12, 13, 14 will be completed by December 27, 2013	

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F 253	Continued From page 18 twenty-six of twenty-six randomly sampled resident rooms no longer had a finish on them. That had caused the wood to waffle (Photo 1). b. Four resident rooms (7, 9, 11, and 20) had corners by the sink that had been chipped exposing the metal corners. c. Five resident rooms (7, 9, 10, 11, and 20) had cupboard doors under the sink with rough chipped wood at ankle level (Photo 2). d. Three resident rooms (7, 13, and 15) had stained wet wood under the sink (Photo 3). e. Three resident rooms (8, 13, and 14) had laminate missing on resident dressers that had exposed the wood making it a non-cleanable surface. f. Six resident bathrooms in rooms (9, 10, 11, 12, 13, and 14) had toilets that needed caulked (Photos 13, 14, and 15). g. In the bathrooms for residents 7 and 8 a section of sheet rock had been missing by the heat register exposing the interior wall (Photo 5). h. The back-splash in the bathroom in resident rooms 3 and 4 had pulled away from the wall leaving a gap and uncleanable surfaces (Photo 6). i. The floor tile in the resident bathrooms of rooms 1, 2, 7, 8, 13, and 14 were chipped or cracked (Photos 7 and 8). j. Four resident fans had been dusty. k. Four ceiling fans in the main dining room had been dusty. l. One cold air return vent in the ceiling by the laundry room had been dusty. m. The advanced Alzheimer's care unit (AACU) had: *Paint chipped on the three of the four walls exposing the gypsum board (Photo 9). *One metal fire door frame had paint chipped and peeling (Photo 10).	F 253	g. The sections of missing sheet rock by the heat register in resident rooms 7, 8, will be replaced by December 27, 2013 h. The back-splash in resident rooms 3 and [redacted] will be caulked, creating a cleanable surface by December 27, 2013. i. The chipped floor tile in resident bathrooms, rooms 1, 2, 4, 8, 13, and 14 replacement will be contracted by December 27, 2013 j. Resident fans will be cleaned by the housekeeping service December 27, 2013 k. Four ceiling fans in the main dining room will be cleaned by maintenance by December 27, 2013 l. The cold air return vent in the ceiling by the laundry room was cleaned on 11/27/13 m. AACU corrections: 1. paint the chipped areas on the walls with exposed gypsum board by December 27, 2013 2. scrape the peeling paint and paint the metal fire door frame December 27, 2013	

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F 253	Continued From page 19 Interview during that environmental walk-through with the MS confirmed the above findings. He stated the previous MS had resigned approximately two months ago. He had been working at the facility eight hours a week for the last five weeks. He had been concentrating on the safety issues of the facility. Interview on 11/6/13 at 9:15 a.m. with the housekeeping supervisor confirmed the personal fans had not been cleaned. She had been instructed maintenance was to have cleaned them. The fans had been dusty due to the construction that had been occurring with the facility. The fans had not been dusted daily to prevent dirt buildup. Interview on 11/7/13 at 8:30 a.m. with the director of nursing confirmed the previous MS had resigned approximately two months ago and the MS from another facility had been filling in. She confirmed the resident's personal fans had not been cleaned. The provider had been looking into contracts to see who was to have been cleaning them. Review of the provider's 2001 MED-PASS policy of Cleaning and Disinfection of Environmental Surfaces revealed "Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA Bloodborne Pathogen Standard." Surveyor: 32333 2. Random observations in the north medication	F 253	2a. Defrost the north medication room refrigerator/freezer by December 27, 2013 b. Defrost the south medication room freezer by December 27, 2013 All resident rooms will be audited for un-cleanable surfaces, cracks, peeling and chips in paint, doorways, cabinets, flooring and walls, dusty fans and vents December 27, 2013 All residents have the potential to be affected. 2. Staff education will be completed for observation and reporting of maintenance repairs and how to report the maintenance requests by December 27, 2013. The Maintenance Director or designee will complete the preventative maintenance program and address issues identified in the monthly/quarterly/semi-annual and annual maintenance audits. The Administrator or designee will monitor the PM audit completion monthly x 3 and randomly thereafter. 3. The completion of the items outlined above will be reported to the QAPI committee upon completion. The monthly PM audits will be completed and the findings reported to the QAPI committee monthly x 3 or until compliance is achieved. * 2c. Edible items were removed from medication refrigerators, lab specimens are maintained in zip lock bags in a seperate refrigerator from medications, and ice packs were discarded. MP/SDDOH/MF	4. 12/27/13

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F 253	Continued From page 20 room and the south medication room revealed: a. The north medication room had a small refrigerator with a freezer in it that had laboratory specimens stored in it (Photo 11). *The north medication room freezer had ice built up on it. b. The south medication room had a refrigerator that had a separate freezer (Photo 12). *The south medication room freezer had resident liquor, ice cream cups, and therapy ice packs stored in it. *The south medication room freezer had ice built up in it. Interview on 11/7/13 at 11:14 a.m. with the director of nursing revealed she would have expected the medication room freezers to have been maintained appropriately and defrosted as needed. Provider: 32572 3. Review of the provider's 8/30/2011 Maintenance Supervisor job description revealed an essential job duty as "Perform minor repairs and supervise the day-to-day repair, improvement and preventative maintenance of the building...." Review of the provider's Quality Assurance monitoring revealed in April 2013 the provider had completed education to "all the staff on the importance of placing environmental concerns into Building Engines (computer concern form that staff complete to notify maintenance of the concern) for resident and staff safety and to ensure building cleanliness."	F 253		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 21 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, policy review, and interview, the provider failed to update and revise care plans for five of twelve residents (1, 4, 5, 7, 8, and 12). Findings include: 1. Review of resident 4's medical record revealed he had fractured his left humerus on 10/5/13. His physician had ordered a sling to have been used on his left arm for that fractured humerus. There had been no mention for the use of his sling included in his current care plan that had been dated 10/18/13. Interview on 11/7/13 at 9:05 a.m. with the	F 280	F280 1. Resident 4 fractured left humerus has healed, he is no longer using a sling. Restorative nurse was educated on 11/26/13 regarding the need to assess and document the reason that a resident was not participating in restorative programming. Please see F248 regarding activity care plan for resident 8. There is no corrective action to be taken for resident 5 restorative programming as resident has discharged. Care plan for resident 12 was updated on 11/14/13 to include diagnosis of vascular dementia, left eye blindness and right eye blurred vision; in addition the care plan for resident 12 was updated to include diet for a mechanical soft diet with honey thickened liquids. Care plan for resident 1 was updated on 11/26/13 to include the presence of knee pain and the use of analgesics per physicians orders. The resident continence by day reports for resident 1 for the MDSs with ARDs of 3/15/13, 6/3/13 and 8/30/13 were reviewed by the MDS coordinator on 11/22/13 and found to be coded correctly for urinary continence and constipation. The care plan for resident 1 was updated on 11/22/13 to include urinary incontinence. The care plan for resident 7 was updated on 11/29/13 to include potential dental issues and her role as acting resident council president was updated on 11/18/13.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 22 Alzheimer's unit director revealed she agreed resident 4's care plan had not been updated to include the use of his sling. Surveyor: 32333 2. Review of resident 5's 7/15/13 care plan revealed: *A focus area of physical functioning deficit (weakness) with a risk for decline related to a diagnosis of dementia and a history of hip fracture. *A goal was she would maintain her current level of physical functioning and maintain upper and lower range of motion (ROM) for ease with activities of daily living (ADLs). *Interventions included: -Encourage choices with care. -Monitor and report changes in ROM ability. -Restorative care completed up to seven days per week. -Wheelchair as primary mode of locomotion (movement). Review of resident 5's progress notes revealed 10/3/13 "Restorative program evaluation for September: AROM (active range of motion): AROM to upper and lower extremities all joints in pain free range times ten repetitions each. Group exercise (toss, kick, and stretch). Complete up to seven days per week. Goal: Maintain upper and lower ROM for ease with ADLs, mobility, and transfers. Resident is no longer participating in the programs. Will discontinue program." Interview on 11/6/13 at 9:40 a.m. with the restorative nurse revealed:	F 280	All residents have the potential to be affected. 2. Care plan team was educated on 11/26/13 regarding the need to review and revise the residents care plan to meet a residents needs. 3. DNS or designee will audit 5 resident care plans to ensure that care plans address resident needs. Audits will be completed weekly x 4 weeks then monthly x 3 until all residents care plans have been audited. Audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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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F 280	Continued From page 23 *She did not assess the need or discharge of restorative care for the residents in the AACU. *If a resident refused restorative care for one week she discharged them from the program. *She did not assess why the resident might be refusing restorative care, she just relied on the CNAs to do that. *There was one restorative CNA. *She did not provide restorative care in the AACU. *The CNAs working in the AACU were responsible for doing restorative care for those residents. 3. Review of resident 8's 3/22/13 care plan revealed: *A focus area "Due to cognitive loss, impaired communication, diminished decision making capabilities and safety and security issues, placement in the secure Alzheimer's care unit with programs designed for this population is needed as evidenced by moderate to severe cognitive loss due to Alzheimer's disease." *"An intervention to provide normalized programming based on patient assessment and interests refer to activity care plan." *There was no activity care plan. Refer to F248, finding 1d. 4. Review of resident 12's entire medical record revealed: *She had been admitted on 11/1/13. *She had diagnoses of vascular dementia, left eye blindness, and right eye blurred vision. *11/4/13 physician's order for a mechanical soft diet with honey thickened liquids. Review of resident 12's care plan revealed no mention of the above listed diagnoses or diet	F 280		

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F 280	Continued From page 24 order. 5. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed she would have expected resident care plans to have been complete, accurate, and up-to-date to reflect the resident's current care needs. Surveyor: 32572 7. Review of resident 1's medical record revealed: *She had been admitted on 3/6/13. *Her diagnoses had been: -Memory loss. -Iron deficiency anemia. -Constipation. -Falls. -Dementia (decline in thought processes). -Cataract (clouding of the vision of the eye). -Cerebrovascular disease (stroke). -Psychosis (mental illness). -Depressive disorder. -Muscle weakness. -Anxiety. -Aphasia (unable to talk). -Suicidal ideation (thoughts). -Reflux (heartburn). -Hypertension (high blood pressure). -Myalgia (pain in muscles). -Myositis (inflammation in muscles). *The minimum data sets (MDS) dated 6/3/13 and 8/30/13 indicated the resident had not been in pain. *There had been a care plan dated 3/20/13 with a focus area for pain management and monitoring. -A goal for the pain focus had been "Patient will achieve acceptable pain level goal with a target	F 280		

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F 280	Continued From page 25 date of 6/20/13." -Another goal had been "Will maintain adequate level of comfort as evidenced by no s/sx (signs or symptoms) of unrelieved pain or distress, or verbalizing (telling of the staff) satisfaction with level of comfort and a target date of 6/20/13." -The care plan had not indicated the resident had pain. *On 10/10/13 the physician had changed the plan of care and had prescribed a cream for her knee pain to be applied twice a day. -The care plan had not indicated the physician had ordered a cream for knee pain. *There had been a revised care plan dated 8/30/13 for problems with bowel (stool) elimination related to constipation. -The MDS dated 3/15/13 and 6/3/13 indicated she had been continent (control) of bowel elimination. -The MDS dated 8/30/13 indicated she had been occasionally incontinent (no control) of bowel elimination. -The MDS dated 3/15/13, 6/3/13, and 8/30/13 indicated she did not have constipation. *The MDS dated 3/15/13, 6/3/13, and 8/30/13 revealed her urinary continence had been coded as occasionally incontinent. -There had not been any mention of her urinary (bladder) incontinence on the current care plan. Interview on 11/7/13 at 8:30 a.m. with the DON revealed: *The DON indicated the resident had been continent of urine. *The DON left the room and interviewed staff. *She returned and stated resident 1 was	F 280		

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F 280	Continued From page 26 continent. *The current MDS had been shown to her, and she nodded in agreement when questioned if the MDS had been coded inaccurately. *She had agreed if resident 1 had been incontinent of urine it should have been care planned. 9. Review of resident 7's medical record revealed: *She had been admitted on 12/4/12. *Her diagnoses had been: -Alzheimer's disease (decline in thought processes). -Restless leg syndrome. -Edema (fluid). -Hypertension. -Congestive heart failure (fluid around the heart). -Renal (kidney) failure. -Macular degeneration (deterioration of eye sight). -Arthropathy (disease of the joints) of multiple sites. -Urinary tract infections. *Her MDS care area assessment (CAA) indicated dental care had been care planned. -Review of her revised 8/28/13 current care plans had not indicated dental issues had been care planned. *She had been acting as the resident council president. -The volunteer care plan had not indicated she had been the president. -The recreational activities care plan had not indicated she had been the president. 10. Interview on 11/7/13 at 8:30 a.m. with the DON confirmed she would have expected the	F 280		

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F 280	Continued From page 27 care plans to have reflected the current care provided and needed for the above resident. Interview on 11/7/13 at 9:30 a.m. with the activity director confirmed the care plans should reflect the current treatment plans. Resident 7's care plan should have included she had been the resident council president. Review of the provider's revised October 2009 Interdisciplinary Care Plan policy revealed: *"The interdisciplinary care plan will be revised at least quarterly to evaluate effectiveness and be revised/updated as necessary to address resident needs in accordance with the most current assessment." *"Interventions that proved ineffective must be changed on the care plans immediately." Review of the resident assessment instrument (RAI) manual, September 2010, p. Q-1, revealed "Planning for Care should be individualized and resident-driven."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to: *Follow physician's orders for the use of a Tabs monitor (a device that sounds an alarm with a lot of movement) for one of one sampled resident	F 281		

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F 281	Continued From page 28 (6). *Follow physician's orders for the use of a sling for one of one sampled resident (4). *Administer eye drops according to physician's orders by one of one licensed practical nurse (LPN) (K) observed during a medication pass for one of one sampled resident (8). *Clarify physician's orders for the administration of an inhaler administered by one of one LPN (K) to one of two residents (17) observed during a medication pass. Findings include: 1. Review of resident 6's October 2013 physician's orders revealed an order for a Tabs monitor. Multiple observations on 11/5/13 from 8:30 a.m. through 5:30 p.m. revealed the Tabs monitor had not been in use. Interview on 11/7/13 at 10:30 a.m. with the director of nurses (DON) revealed the physician had not been notified the Tabs monitor had not always been used. 2. Review of resident 4's medical record revealed he recently had a fall. His physician had ordered a sling to his left arm for a fractured humerus. He had follow-up appointments on 10/24/13 and 11/2/13. The physician had ordered the continued use of the sling to his left arm. Multiple observations on 11/5/13 throughout the entire day from 10:00 a.m. through 5:00 p.m. revealed he had the sling on, but it had been improperly positioned. He had been moving his left arm forward to reach for items, reached his arm downward towards the floor, and had put his left hand in his pocket several times. He had used his left arm to pick up a cup and drink from it. The sling continually hung off the back of his elbow.	F 281	F281 1. The Tabs alarm for resident 6 was put into place immediately upon notification that the alarm was not in use. Resident 4 is no longer using a sling. *1 MP/SDDDH/MF The physician for resident [redacted] was contacted on 11/25/13 and clarification orders were received regarding Symbicort as it pertains to the number of puffs to inhale with each administration. LPN K was educated verbally by the DNS on 11/7/13 regarding the directions for use of dorzolamide hydrochloride 2% eye drops for resident 17 and the correct procedure for following physicians orders during administration of medications. All residents have the potential to be affected. 2. Staff will be educated by 12/5/13 regarding the need to adjust a residents sling should it become incorrectly positioned. Staff responsible for medication administration will be educated by 12/5/13 regarding the need to follow physicians orders during medication administration and to clarify any orders that are not complete with the physician prior to administration. KR	

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F 281	Continued From page 29 There had been several staff members in sight when he had not used his sling throughout the day. Those staff members had included the Alzheimer's unit director, CNAs, and the clinical educator. No staff member had attempted to reposition his left arm properly into the sling. Interview on 11/7/13 at 9:05 a.m. with the Alzheimer's care director revealed she agreed resident 4's sling was not positioned correctly. The staff had not cued or assisted him with his sling. Interview on 11/7/13 at 9:30 a.m. with the DON revealed the physician had not been contacted regarding the improper use of resident 4's sling. Surveyor: 32333 3. Observation on 11/5/13 at 8:35 a.m. of licensed practical nurse (LPN) K while administering medications to resident 17 during medication pass revealed: *The resident had a Symbicort 80-4.5 microgram (mcg) inhaler. *The LPN handed the inhaler to the resident. *The resident took one puff of the inhaler then rinsed her mouth. Review of the label on the Symbicort box revealed: *To use one to two times per day. *The directions for use had not included how many puffs to inhale. Review of resident 17's 10/31/13 physician's orders revealed an order for Symbicort 80-4.5 mcg two times daily.	F 281	3. DNS or designee will audit 5 residents medication pass to ensure that physicians orders are complete and staff administering medications follow physicians orders. Audits will be completed weekly x 4 then monthly x 3 until all staff responsible for medication pass have been audited. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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F 281	Continued From page 30 Review of resident 17's November 2013 medication administration record (MAR) revealed Symbicort inhalation 80-4.5 mcg two times a day. 4. Observation on 11/5/13 at 2:45 p.m. with LPN K while administering dorzolamide hydrochloride (HCL) 2 percent (%) eye drops to resident 8 revealed she had put one drop into each eye. Review of the label on the dorzolamide HCL 2% eye drop box revealed "Instill one drop three times daily into the left eye." Review of resident 8's 10/4/13 physician's orders revealed dorzolamide HCL 2% one drop three times a day in left eye. Review of resident 8's November 2013 MAR revealed dorzolamide HCL 2% one drop three times a day in left eye. 5. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed: *She would have expected clarification of resident 17's physician's order for Symbicort to include how many puffs to inhale. *She would have expected staff qualified to administer medications to follow the physician's order. Review of the provider's revised August 2012 Administering Medications policy revealed: *"Medications must be administered in accordance with the orders, including any required time frame." *"The individual administering the medication must check the label THREE times to verify the right resident, right medication, right dosage, right time and right route of administration before	F 281		

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F 281	Continued From page 31 giving the medication."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on record review, interview, and policy review, the provider failed to render the necessary services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one of one sampled resident (2) who had spent most of his waking hours in a wheelchair or recliner near the nurse's desk every day. Findings include: 1. Review of resident 2's 10/24/13 physician's orders revealed he had been admitted on 4/12/13. He had diagnoses of arthritis, dementia, muscle weakness, and an abnormal way of walking that would have affected his activities of daily living (ADL). Observation at the following times revealed: *On 11/4/13 at 3:30 p.m. resident 2 had been seated in the lobby in a recliner. *On 11/5/13 at 8:30 a.m. the resident was up and	F 309	The resident population was evaluated and no other residents were identified in this area at that time. MDS/DON/MF F309 1. MDS Coordinator discussed restorative nursing program with resident 2's wife on 11/6/13, she has refused to agree to resident participating in restorative nursing There is no corrective action to be taken for resident 2 activity programming and care plan as resident 2 has discharged. * Please see F318 regarding restorative documentation. All residents with cognitive impairment have potential to be affected. 2. Administrator, DNS, governing body and interdisciplinary team reviewed the policy and procedure regarding the provision of care on 11/26 /13. No revisions were made. Directed in-service training will be provided to staff by 12/5/13 regarding provision of care that meets the residents physical, mental and psychosocial well being.	

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F 309	Continued From page 32 out of his room. *On 11/5/13 from 10:00 a.m. through 5:00 p.m. the resident remained in his wheelchair or the recliner seated in the lobby area most of that time except for meals. *On 11/6/13: -From 9:00 a.m. through 10:30 a.m. the resident remained in his wheelchair in the lobby area. -He went to an activity at 10:30 a.m. -At 1:30 p.m. he had been awake and seated in the recliner in the lobby. -He remained in the recliner until his wife came to help him with supper around 5:00 p.m. *On 11/7/13 from 7:50 a.m. through 8:50 a.m. the resident was dressed and lying in his bed. Review of the resident's nursing progress notes on 9/21/13 at 9:43 a.m. revealed the resident had been found on the floor of the front lobby. He had been seated in his wheelchair with a lap buddy (a cushion placed across the front of the wheelchair seat that keeps the resident from standing up) in place before the fall. He had no injuries documented for that fall. He had been assisted back into his wheelchair and placed at the nurse's station. It further stated the resident would continue to be kept in clear view of the staff at all times. Interview on 11/5/13 at 4:50 p.m. with resident 2's wife confirmed the resident had not been allowed to lie down for a nap during the day. He had been made to stay at the nurse's desk area. He had remained in his wheelchair or in a recliner in the lobby. She had just bought him a new wheelchair that was more comfortable to sit in. It caused him to be tipped back more than a regular wheelchair and had special padding. He had just gotten that on the evening of 11/4/13. Before then he had	F 309	3. DNS or designee will audit 5 residents medical record to ensure care and services are being provided that meet the residents physical, mental and psychosocial well being. Audits will be completed weekly x 4 then monthly x 3. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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F 309	Continued From page 33 been in a regular wheelchair. She had to buy the wheelchair herself as the facility had refused to buy it for him. Interview on 11/6/13 at 10:30 a.m. with certified nursing assistant (CNA) G confirmed the resident had been kept in a wheelchair or a recliner in the lobby near the nurse's desk. He had not been allowed to be in his room alone except at night to sleep. He had been allowed to be in his room if his wife was with him. At night he was in a low bed with a mat on the floor next to the bed. That had been because he was a fall risk. Observation and interview on 11/7/13 at 8:50 a.m. with CNA B and G confirmed that had been the first day the resident had been allowed to lie down in bed after breakfast. Before that his wife had not wanted him to be alone in his room. She had been afraid he would fall. They assisted him out of bed and to the bathroom at that time. After he was done in the bathroom he was assisted into his wheelchair and taken out of his room. Interview on 11/7/13 at 9:05 a.m. with the director of nursing (DON) confirmed the resident had been laid down that morning after breakfast. Prior to this morning he had always stayed up in his wheelchair or a recliner in the lobby near the nurse's desk. That had been because his wife had been afraid he would fall if left alone in his room. She had agreed it had not been a good environment for the resident to get needed rest. When asked what activities or interventions had been used at the times he had been restless and at risk for falling she stated they had used medications and adjusted them when needed to address his behaviors. They had also kept him at the nurse's desk for observation. When asked	F 309		

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F 309	Continued From page 34 specifically for non-medication interventions, for example one-to-one activities or ambulation, she had stated the resident's activity schedule would have to be reviewed for that information. She had been unable to state what interventions had been used at those times. She had further confirmed they had been unable to find his documented activities prior to October 2013. Those months were missing. She had believed the wife was afraid restorative nursing would cost more and had refused it for the resident. When asked who they had been responsible to serve, the wife or the resident, she had stated the resident was to have been their first consideration. She had agreed other approaches could have been used with the wife to ensure the resident's activities of daily living would have been maintained. Review of the resident's nursing progress notes revealed on 7/31/13 the resident's restorative program evaluation had showed he had completed the programs as directed. He had shown improvement and willingness to complete the restorative program. He had been evaluated by skilled services and had been started on skilled therapy. Restorative was then placed on hold. No discharge summary had been documented when restorative had been discontinued on 9/2/13 that had identified why a nursing restorative program was no longer appropriate. Review of the resident's 9/19/13 care plan revealed he had received restorative nursing. The goals were to maintain his upper and lower body strength, range of motion, and his ability to walk. It had been documented as starting on 6/23/13 and had been discontinued on 9/2/13. He continued to have a focus listed for physical	F 309		

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F 309	Continued From page 35 functioning deficit related to weakness and impaired cognition (mental function). The goals for that focus remained that he would improve his current level of physical functioning and maintain his current level of range of motion. Interventions to maintain his level of physical functioning and range of motion had been discontinued on 9/2/13. His care plan had also listed a focus of being at risk for falls. It had an intervention that the resident was to have remained in common areas in view of the staff. Interview on 11/6/13 from 2:25 p.m. through 3:30 p.m. with the restorative registered nurse (RN) confirmed resident 2 had been discharged from skilled therapy as he had not been making progress. He had not been receiving any restorative therapy from nursing. She further confirmed she had not offered a restorative nursing program for him to the resident's wife. She had felt his wife would have refused it, since she had refused the skilled therapy for the resident. Interview on 11/6/13 at 3:18 p.m. with the restorative RN confirmed she had no definitive answer as to how range of motion decline would have been prevented for resident 2. She stated he would not participate in a rehabilitative program. When asked if he took part in activities that involved range of motion she stated she had not known and the activity coordinator would have to be asked. She had monitored only the residents with a restorative program, no others. Interview on 11/7/13 at 10:30 a.m. with restorative aide G confirmed resident 2 came to exercise group but had not always actively participated. She stated the activity coordinator would have	F 309		

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F 309	Continued From page 36 documented his participation in the exercise group since he did not have a restorative program. Resident 2's activities record review revealed: *No activity records were available prior to October 2013. *In October 2013 he had attended activities sixteen days out of thirty-one days of the month. *He had refused activities on six of those days. *There had been eight days no activity had been recorded as attended or refused by the resident. *From November 1 through November 6, 2013, the resident had an activity recorded four of those six days. -He had not attended an activity on the other two days. *The resident had attended exercise only one time from October 1 through November 6, 2013. Review of the provider's revised 2013 Restorative Guideline revealed some of the criteria for selection for a restorative program had been: *A diagnosis that was likely to cause functional decline. *A recent admission to the facility and not receiving active therapy. *Recent completion of an active therapy program. *A decline in ADL function. *Restrictions on the resident's activity level. Review of the provider's revised 2013 Restorative Guideline revealed some of the criteria for discharge from the restorative program had been: *When restorative goals had not been met. *The resident would no longer benefit from the program.	F 309		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		

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F 312 SS=E	Continued From page 37 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to: *Provide assistance for one of six residents (21) that needed assistance with eating in the advanced Alzheimer's care unit (AACU). *Ensure the face of one of six residents (23) had been cleaned while being assisted with eating in the AACU. *Ensure one of one observed resident (26) in the AACU remained free from facial hair. *Ensure one of three sampled residents (12) had clean and dry outer clothes while transferring her to the dining room table. Findings include: 1. Observation on 11/5/13 from noon through 12:30 p.m. of the noon meal service in the AACU revealed: *A table with six residents, 20, 21, 22, 23, 24, 25, that required feeding assistance. *Resident 21 had a glass of milk in his hand and had dumped it on himself and the floor. *At 12:05 p.m. all six residents at that table had been served their meals. *At 12:10 p.m. certified nursing assistants (CNA) M and P and the Alzheimer's care unit (ACU) director sat down to help feed the residents.	F 312	F 312 1. Resident 12 was toileted and cares were provided by staff immediately upon being notified of soiled clothing. C.N.A. M, C.N.A. P, and Alzheimer's Care Director will be educated by the DNS or designee on dignity and respect of residents, personal grooming, ensuring assistance is available for each individual during meal time, and ensuring residents are appropriately dressed , clean and dry by 12/5/13. All residents have the potential to be affected. 2. All staff will be educated on the Policy and Procedure ensuring resident rights to dignity and respect including the following: what constitutes dignity and respect, personal grooming of residents, ensuring residents are appropriately dressed, clean and dry and ensuring assistance is available for each resident for dining and other needs by 12/5/13. Education will be provided to all staff on the policies and procedures about the provision of care by the DNS or designee by 12/5/13. The Administrator, DNS, governing body and interdisciplinary team reviewed the policy and procedure ensuring resident right to dignity and respect on 11/26/13. No revisions were made. 3. The DNS or designee will randomly audit: 5 residents to ensure assistance is available for each individual during meal time, to ensure that dignity is maintained	

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F 312	Continued From page 38 *At 12:25 p.m. the ACU director and CNA M had left the dining room helping other residents. CNA P was left at the table with four residents that had required feeding assistance. *At 12:30 p.m. resident 21 had been at the table with his full plate of food in front of him with no assistance offered to him to help eat his meal. No one had helped clean him up after he had spilled his milk. *Resident 23 had food running down her face and chin. *Resident 26 had been sitting at another table in the dining room. She had visible chin hairs on her face from across the room. 2. Observation on 11/6/13 at 5:35 p.m. of CNA N helping transfer resident 12 in the AACU dining room revealed: *The resident had been sitting in a chair in the dining room. *The CNA helped the resident out of the dining room chair to move her to her place in the dining room for the supper meal service. *When the CNA helped the resident stand her pants were visibly wet on the back side of her. *There had been a strong smell of urine. *The chair the resident had been sitting in was wet. *The floor near where the resident had been sitting had been wet. *The CNA walked the resident to where she sat for the supper meal service and helped her sit down. *This surveyor approached the CNA and told her the resident had been wet. *The CNA then took the resident out of the dining room to assist her to the bathroom. *That left one CNA,O, in the dining room to assist approximately fourteen residents.	F 312	during the meal service to include the absence any food on the resident's face or clothing, and for proper grooming to include any excess facial hair weekly x 4 and then monthly x 3 to ensure compliance. The DNS or designee will report audit results to the monthly QAPI Committee for further review and recommendations.	4. 12/27/13

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F 312	Continued From page 39 Interview on 11/7/13 at 9:30 a.m. with the Alzheimer's care director confirmed it was unacceptable for resident 21 not to have been fed. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed she would have expected: *Appropriate assistance offered to residents requiring feeding assistance during meal service. *Male and female residents to have been shaved and groomed. *Residents to have been toileted in a timely manner.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to: *Maintain an effective restorative care program for all residents who received restorative care in one of one advanced Alzheimer's care unit (AACU). *Ensure one of one sampled resident (2) had been appropriately assessed for the need for	F 318		

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F 318	Continued From page 40 restorative care. Findings include: 1. Interview on 11/6/13 at 9:40 a.m. with the restorative nurse revealed: *She did not assess the need or discharge of restorative care for the residents in the AACU. *If a resident refused restorative care for one week she discharged them from the program. *She did not assess why the resident might have been refusing restorative care, she just relied on the certified nursing assistants (CNAs) to do that. *There was one restorative CNA. *She did not provide restorative care in the AACU. *The CNAs working in the AACU were responsible for doing restorative care for those residents. Interview on 11/6/13 at 9:45 a.m. with CNA M who worked in the AACU revealed: *Two CNAs had been scheduled from 6:00 a.m. through 10:00 p.m. daily in the AACU. *One CNA had been scheduled from 10:00 p.m. through 6:00 a.m. in the AACU and in the ACU. *Those CNAs had been responsible for all activities of daily living (ADLs) including bathing/showering, dressing, grooming, feeding, as well as activities, and the restorative program. 2. Review of resident 5's 7/15/13 care plan revealed: *A focus area she had a physical functioning deficit with a risk for decline related to a diagnosis of dementia and a history of hip fracture. *A goal she would maintain her current level of physical functioning and maintain upper and lower range of motion (ROM) for ease with activities of daily living (ADLs).	F 318	The resident population was evaluated & no other residents were identified at this time. MP/SDDOH/MF F318 1. Restorative nurse was educated on 11/26/13 regarding the need to perform an assessment and document and assessment for those residents who refuse restorative programs prior to those residents being discharged from restorative programming, including those residents who reside on the ACU and the AACU. * Please refer to F353 regarding staffing on the ACU and AACU. An assessment to determine if resident is appropriate for a restorative program vs. an activity program will be completed by the restorative nurse and the ACD by 12/27/13 for resident 5. Resident 5 care plan will be updated by 12/27/13 regarding the results of the above assessment. Please refer to F309 regarding resident 2. All residents have to potential to be affected. 2. Administrator, DNS, governing body and interdisciplinary team reviewed the policy and procedure regarding the provision of care on 11/26/13. No revisions were made. Directed in-service training will be provided to staff by 12/5/13 regarding provision of care that meets the residents physical, mental and psychosocial well being.	

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F 318	Continued From page 41 *Interventions included: -Encourage choices with care. -Monitor and report changes in ROM ability. -Restorative care completed up to seven days per week. -Wheelchair as primary mode of locomotion (movement). Review of resident 5's progress notes revealed 10/3/13 "Restorative program evaluation for September: AROM (active range of motion): AROM to upper and lower extremities all joints in pain-free range times ten repetitions each. Group exercise (toss, kick, and stretch). Complete up to seven days per week. Goal: Maintain upper and lower ROM for ease with ADLs, mobility, and transfers. Resident is no longer participating in the programs. Will discontinue program." Review of resident 5's activities revealed she had actively participated daily in exercise. Refer to F248, finding 1c. Review of resident 5's 7/15/13 care plan revealed an intervention for as needed seat belt physical restraint. Refer to F221, finding 1. Review of the provider's Restraint Evaluation and Utilization Guideline revealed "Restorative care to enhance abilities to stand, transfer, and walk." Surveyor: 28057 2. Review of resident 2's 9/19/13 care plan revealed the provider failed to ensure resident 2 had a restorative program in place to maintain, if not improve, his range of motion. Refer to F309, finding 1.	F 318	3. DNS or designee will audit 5 residents restorative nursing progress notes to ensure that an assessment has been completed determining why a resident is refusing restorative programming prior to being discharged from restorative nursing. Audits will be completed weekly x4 then monthly x 3. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.	4. 12/27/13
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=E	Continued From page 42 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, interview, and policy review, the provider failed to ensure the facility environment remained free of accident hazards evidenced by: *Two of two residents (18 and 19) from the Alzheimer's Care Unit (ACU) had not been adequately supervised in the courtyard. *Eleven residents from the ACU had not been prevented unsupervised access to the outside courtyard. *An unsecured Exelon medication patch belonging to one randomly observed resident (5) in the Advanced Alzheimer's Care Unit (AACU). *One unsecured oxygen tank in a medication room. Findings include: 1. Observation and interview on 11/5/13 at 8:35 a.m. revealed residents 18 and 19 were outside in the courtyard. They were banging on the door wanting to come back inside. No code had been displayed to open the door. This surveyor had been unable to open the door to let them inside, as it was locked from the inside. No code had been posted to open the door. Two staff	F 323	No residents are to be unsupervised in the ACU courtyard until door alarm & locking devices are replaced. mp/SDDOH/mf F323 1. The locking device on the ACU door to the courtyard will be evaluated by [redacted] * mp/SDDOH/mf United Technologies, on 12/3/13 and a plan will be in place by December 27, 2013 to ensure safety and security of the ACU residents.* CNA M was educated on 11/26/13 regarding the need to report to a nurse regarding any medications that were removed by the resident allowing for medication to be disposed of appropriately. The oxygen tank in the north medication room was secured immediately upon notification that it was not secured. All residents have the potential to be affected.. 2. Administrator, DNS, governing body and interdisciplinary team reviewed the policy and procedure regarding the provision of care on 11/26/13. No revisions were made. Directed in-service training will provided to staff by 12/5/13 regarding provision of care that meets the residents physical, mental and psychosocial well being, including the necessity to maintain an environment that promotes resident safety.	

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F 323	Continued From page 43 members had walked by the intersecting hallway approximately twenty feet away from that door. They had not responded to the banging on the door. This surveyor had alerted the staff members the residents had wanted inside. CNA H had let them in after she had entered the code to open the door. The residents had stated it was cold outside. Observation at 8:00 a.m. one half hour before the residents were noted outside revealed the bank thermometer had a temperature of 32 degrees Fahrenheit. Certified nursing assistant (CNA) H stated she had let them outside. She confirmed that had been a daily practice for those two residents to go outside every day for about fifteen minutes. She would look out the door about every five minutes to be sure they had been okay. She confirmed the door was locked from both sides and could be opened only with the code. She agreed there had been no way for residents outside to call for help except to bang on the door. There had been no doorbell. She further stated the door had been propped open by staff at times when residents had been outside. She stated she knew they were not supposed to prop the door open as other residents would have been able to go outside unattended. Observation 11/6/13 at 5:00 p.m. revealed the door to the courtyard in the ACU had been propped open with a clothespin (photo 27). No staff had been in sight of the door at that time. No residents had been outside in the courtyard at that time. Interview on 11/6/13 at 5:05 p.m. with CNA L working in the ACU confirmed the door had been propped open. She stated the door had been propped open almost every day. She had not	F 323	3. Maintenance personnel or designee will audit exits to ensure they alarm, lock and un-lock properly weekly x 4 then monthly x 3. Results of these audits will be presented by the Maintenance personnel to the monthly QAPI committee for review and recommendation. DNS or designee will perform random audit of residents environment to ensure that medications are properly secured. Audits will be completed weekly x 4, then monthly x 3. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation. Maintenance personnel or designee will audit oxygen tank storage in north medication room to ensure that oxygen tanks are properly secured. Audits will be completed weekly x 4, then monthly x 3. Results of these audits will be presented by maintenance personnel to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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F 323	Continued From page 44 been sure who had propped it open on that day. Interview on 11/6/13 at 5:20 p.m. with the ACU coordinator confirmed she had believed one of the residents had propped the door open. She said there had been only one staff member in the ACU routinely. If that staff member had let a resident or residents outside they were to have been monitored until they had come back inside. She agreed it was possible for the one staff member to get busy inside if something occurred on the unit causing the resident to remain outside for an extended period of time without staff monitoring. She stated that could have happened inside too, but agreed that weather was not a factor on the inside. She confirmed the code and a note that stated not to prop the door open had been posted at the door. She said the residents had kept tearing those notes down. Interview on 11/7/13 at 12:00 noon with the administrator confirmed it would have been safer if residents could get back inside independently from the courtyard during the daytime hours. They had not been out in the evening and nighttime hours. She agreed it was possible for the staff to get busy inside if something occurred on the unit causing the resident to remain outside for an extended period of time without staff monitoring. Review of the provider's undated Accident Prevention Policy revealed: *The safety committee was to have inspected all areas of the building twice a year. *The committee was to have looked for unsafe practices or unsafe shortcuts. *Identify physical hazards that could result in an injury.	F 323		

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F 323	Continued From page 45 *It had not directly addressed locking of doors or the ACU courtyard. Surveyor: 32572 Interview on 11/6/13 at 8:30 a.m. with the temporary part time maintenance supervisor from another Golden Living Center revealed he had been working at the facility eight hours a week for the last five weeks. He had been concentrating on the safety issues of the facility. Surveyor: 32333 2. Observation on 11/5/13 from 9:20 a.m. through 10:00 a.m. of resident 5 in the advanced Alzheimer's care unit revealed: *She had been sitting in her wheelchair in the day room with her eyes closed. *At 9:40 a.m. she had her Exelon patch in her hand and was rolling it around in her hand. *At 9:50 a.m. CNA M took the Exelon patch from her hand and wheeled the resident to her room. *CNA M set the Exelon patch on top of the resident's dresser and left the resident's room. *Resident 5's roommate had also been in the room. *At 9:55 a.m. CNA M returned to the resident's room and assisted her into the bathroom. *At that time licensed practical nurse K arrived to the resident's room and reapplied the Exelon patch onto resident 5's back. 3. Observation on 11/7/13 at 8:55 a.m. in the	F 323		

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F 323	Continued From page 46 north medication room revealed an unsecured oxygen tank lying on its side on a shelf (photo 39). 4. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed: *Medications should have been secured at all times. *She would have expected CNA M to have taken the Exelon patch to nurse instead of leaving it on the resident's dresser. *She would have expected oxygen tanks to have been secured.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.	F 353	F353 1. On 11/25/13 a meeting regarding staffing on the ACU and AACU was held with Administrator, DNS and Alzheimer's Care Director (ACD) present. All residents who reside in the ACU and AACU have the potential to be effected by this practice 2. ACD and DNS were educated on 12/2/13 regarding the need for adequate staffing on the ACU/AACU to ensure necessary care and services to maintain the highest practicable level of physical and psychosocial well being. 3. Administrator or designee will audit staffing in the ACU/AACU weekly x 4 then monthly x 3 to ensure that adequate staffing is provided to ensure necessary care and services to maintain the highest practicable level of physical and psychosocial well being. The results of these audits will be presented by the Administrator to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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F 353	Continued From page 47 This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate staffing to provide necessary care and services to maintain the highest practicable level of physical and psychosocial well being in the advanced Alzheimer's care unit (AACU). Findings include: Interview on 11/6/13 at 6:00 p.m. with the director of nursing and the Alzheimer's care director confirmed: *The AACU had sixteen residents. Those resident's required extensive care and assistance. *The Alzheimer's care unit (ACU) had eleven residents. *Two certified nursing assistants (CNAs) were on duty in the AACU from 6:00 a.m. through 10:00 p.m. *One nurse had been on duty in the ACU and AACU from 6:00 a.m. through 10:00 p.m. *One CNA had been on duty in the ACU and AACU from 10:00 p.m. through 6:00 a.m. and had been responsible for all of the residents. No nurse had been on duty in the ACU or AACU during those hours. *The two CNAs scheduled in the AACU during the hours of 6:00 a.m. and 10:00 p.m. had been responsible for all activities of daily living (ADLs) including bathing/showering, grooming, toileting, intervening with behaviors, feeding residents, restorative care, and activities. Refer to F157, F221, F241, F248, F312, F318, F323.	F 353		

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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: 28057 Based on observation, interview, record review, and policy review, the provider failed to store, prepare, and serve food in a sanitary manner as evidenced by: *Two of three observed dietary staff (R and Q) had worn soiled uniforms and aprons. *Improper handling of ready-to-eat food by one of two cooks (Q). *Numerous unclean surfaces in the kitchen. *Lack of timely cleaning of one of one ice machines. *Improper glove use while making a sandwich by one of one observed certified nursing assistant (CNA) H in the advanced Alzheimer's care unit (AACU). *Unsanitary practices by CNA B while she served drinks and buttered buns for residents in the AACU. Findings include: 1. Observation on 11/5/13 from 8:22 a.m. through 11:07 a.m. revealed cook R had been scrubbing soiled pans in the dishwasher area. She then	F 371	F371 1. Worn and soiled aprons were discarded and/or cleaned on 11/26/13. Side of the convection oven was cleaned 11/5/13 Gaps in the light covers will be corrected by replacing light covers by 12/27/13 Light fixtures will be cleaned by 12/27/13 Ceiling pipes will be cleaned by 12/27/13 Ice machine will be cleaned by 12/27/13 Stove back splash was cleaned on 11/22/13 and 11/26/13 Wood cabinet doors will be cleaned by 12/27/13 Stove top griddle grease trap will be cleaned and emptied daily Oven cleaned and foil will be replaced by 12/27/13 and weekly thereafter Caulk around hand washing sink will be replaced by 12/27/13 Dish room wall chips will be repaired and painted by 12/27/13 All resident's have the potential to be affected. 2. Education was provided for all staff regarding cleanliness, cleaning and cleaning schedules, proper glove use, handling of ready to eat food, proper clean to dirty work areas, staff handling of dishware and glassware on 11/26/2013. The Dietary Manager will review the cleaning schedule and educate the staff by 12/27/13.	

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F 371	Continued From page 49 sprayed them and put them into the dishwasher machine. She had a smock top on that had been visibly soiled with wet spots and spatters of colored matter. She had not worn an apron while she had washed the pans. She had then gone back to preparing food for the noon meal. She had held clean dishes against her soiled smock top. She had leaned over the steam table causing her smock top to touch clean serving dishes. Those dishes had been used to serve the noon meal to the residents. Observation on 11/5/13 at 12:20 p.m. revealed cook Q had a visibly soiled apron on while preparing and serving food. She had worn the apron while serving food and washing the soiled dishes. Interview on 11/7/13 at 8:35 a.m. with cook R confirmed the use of aprons had been up to the staff. It had not been required to protect their clothing from one task to another. Review of the 2011 Dining Services Employee Clothing policy revealed aprons were to have been changed when going from one work area to another. They were to have been kept clean and in good repair. They were to have been changed when they had become soiled. 2. Observation on 11/5/13 at 12:10 p.m. revealed cook Q handled bread she had toasted with her bare hands. She had not worn gloves or used a utensil to handle the toast as she had buttered it. She had made a peanut butter and jelly sandwich and again touched the bread with her bare hands. Interview on 11/5/13 at 3:30 p.m. with the dietary manager confirmed the bread should not have	F 371	3. The Dietary Manager will audit the clean to dirty area movement of the staff, clothing and aprons, preparation and serving of ready to eat foods, cleaning schedule completion weekly x 4 then monthly x 2 and report the findings to QAPI monthly x 3. The Administrator will monitor the Dietary Manager's audits x 3 months.	4. 12/27/13

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F 371	Continued From page 50 been handled with bare hands. A tong or gloves should have been used with ready-to-eat foods. 3. Observation from 11/4/13 on initial tour through 3:00 p.m. on 11/7/13 revealed: *Pipes on the ceiling above the cooking area were soiled with visible amounts of lint that could fall onto the stove and food preparation areas (photo 28). *Light fixtures above the food preparation and serving areas were visibly soiled and had gaps in the covers (photo 38). -Those gaps would have allowed glass to fall onto the preparation areas if a light bulb had broken. *The side of the convection oven next to the stove was visibly soiled with a thick layer of greasy food debris (photo 29). *The backsplash of the stove was stained with burned on black debris (photo 30). *The inside of the oven had burned on spills on the surface and on the aluminum foil lining the bottom of the oven (photo 31). *The grease trap for the stove top griddle was over half full with food and grease (photo 32). *The wood cabinet doors had a greasy buildup that could be scraped off with a fingernail (photo 33). *The caulking around the hand washing sink was rough, soiled, and had pulled away from the wall causing it to be uncleanable (photo 34). *The dish washing room had chipped and peeling paint on the walls and the hood above the dishwasher (photos 35 and 36). *The ice machine had a visible mineral buildup on the backsplash and wire grate (photo 37). Interview on 11/5/13 from 3:30 p.m. through 4:45 p.m. with the dietary manager and the registered dietician confirmed:	F 371		

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F 371	Continued From page 51 *The cleaning of the pipes, light fixtures, ice machine, and painting of the kitchen had been the responsibility of the maintenance department. *In the twenty years the dietary manager had worked at the facility maintenance had always cleaned those areas in the kitchen. *It had been done at night when staff had not been working in the kitchen. *The grease trap on the stove was to have been cleaned every day. *It had not been cleaned for two to three days. *That cleaning of the kitchen environment had been an ongoing issue for several months. *They had been short of staff. *Staff from other departments had been filling in under the supervision of the cooks. Review of the registered dietician's 9/17/13 System Evaluation report revealed: *The kitchen had been inspected on the evening of 9/17/13. *Staff shortage remained the biggest concern. *The staff shortage in dietary and maintenance had caused the heavy duty cleaning to not be completed. *That had been due to not enough staff hours to have completed those tasks. *Regular cleaning and maintenance had not been completed on the major appliances. Interview on 11/6/13 at 1:45 p.m. with the temporary maintenance supervisor confirmed: *He had worked only one day a week for the past five weeks. *He had concentrated on life safety issues on those days. *Cleaning had not been a priority. *The last time the ice machine had been cleaned had been on 9/10/12.	F 371		

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F 371	Continued From page 52 *It had been on a preventative maintenance program to be serviced and cleaned once a year. *He offered a copy of the service manual for the ice machine. Review of the Scotsman models MDT5N25 and MDT5N40 ice machine manufacturer's service manual revealed the ice machine was to have been cleaned and serviced twice a year or more often if the hardness of the water supply demanded it. Surveyor: 29162 4. Observation on 11/5/13 at 12:15 p.m. of certified nurse aide (CNA) H while she prepared a sandwich for a resident revealed she put on gloves. With those gloved hands she touched multiple surfaces that included the refrigerator handle, a plate, cupboard drawer handles, butter dish, bread wrapper and tie, and a knife. With those same soiled gloved hands she reached in the clean bread bag and took out two slices of bread. 5. Observation on 11/5/13 from 6:00 p.m. through 6:30 p.m. of CNA B while she served the residents in the advanced Alzheimer's care unit (AACU) revealed she had: *Served two residents the wrong glasses of drinks. She moved the glasses from one resident to the other by placing her hand on top of the glasses and sliding them on the table. The palm area of her hand had touched the drinking rim of the residents' glasses. *Buttered the buns for four different residents. While she had buttered those buns she had used her bare hands to hold the bun and spread the butter on it.	F 371		

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F 371	Continued From page 53 Surveyor: 32333 6. Observation on 11/7/13 at 8:55 a.m. of the north medication room revealed several unlabeled and undated resident food items that included cookies in a plastic Tupperware container, wafers in a plastic bag, and ready-to-eat bags of popcorn (photo 40). Interview on 11/7/13 at 8:55 a.m. with licensed practical nurse E revealed the unlabeled and undated food items belonged to resident 6. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed she would have expected food to have been labeled and dated. It should not have been stored in the medication room.	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	F 425	F 425 1. On 11/7/13 out-dated medications from the south medication cart were disposed of. All medication carts and medication rooms were audited to ensure outdated medication had been disposed of on 12/1/13 by [redacted] the [redacted] DNS. All residents have the potential to be affected. mrs/bdl/mf 2. All nursing staff will be educated on the Medication Administration Policy and Procedure by the Director of Nursing Services by 12/5/13. 3. The DNS or designee will randomly audit one medication cart weekly x 4 and monthly x 3 to ensure compliance. The DNS will report audit results to the monthly QAPI Committee for further review and recommendations.	4. 12/27/13

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F 425	Continued From page 54 services in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure outdated medications had been disposed of and not administered to residents in two of two observed medication carts (south hall medication cart and Alzheimer's care unit (ACU) medication cart). Findings include: 1. Observation on 11/7/13 at 8:05 a.m. of the south hall medication cart revealed: *A stock bottle of aspirin 325 milligram (mg) tablets with an open date of 8/25/13 and an expiration date of July 2013. *A stock bottle of vitamin E-400 soft-gels with an expiration date of June 2012. *A stock bottle of aspirin 325 mg tablets with an expiration date of November 2012. Observation on 11/7/13 at 9:10 a.m. of the ACU medication cart revealed a stock bottle of Bisacodyl 5 mg tablets with an expiration date of July 2013. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed expired medication should have been disposed of and not administered to the residents. Review of the provider's revised August 2012 Administering Medications policy revealed "The expiration/beyond use date on the medication	F 425		

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F 425	Continued From page 55 label must be checked prior to administering."	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 1. Medications for resident 27 were removed from under sink in the north medication room by LPN E on 11/7/13. Fentanyl Patches for resident 23 were placed under double lock in Narcotic box of the medication cart by LPN K on 11/7/13. All residents have the potential to be affected. 2. Education will be provided to staff responsible for disposal of medication on 11/26/13 regarding the proper procedure for storage and disposal of medications. 3. DNS or Designee will conduct audits of the medications carts and Medication room to ensure that medications are stored and disposed of properly. Audits will be completed weekly x 4 then monthly x 3. Results of these audits will be presented by the DNS to the monthly QAPI committee for review and recommendation.	4. 12/27/13

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F 431	Continued From page 56 This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to: *Lock schedule II narcotic medication awaiting destruction in a separately locked permanently affixed compartment in one of two observed medication carts (Alzheimer's unit medication cart) for one randomly observed resident (23). *Properly store medication in one of two medication rooms (north medication room). Findings include: 1. Observation on 11/7/13 of the Alzheimer's care unit (ACU) medication cart revealed two Fentanyl patches in a medication cup in the top drawer of the medication cart. Interview on 11/7/13 with licensed practical nurse (LPN) K revealed: *She had removed the Fentanyl patches from resident 23. One patch was 100 micrograms (mcg) and the other had been 25 mcg. *She had put them in the top drawer of the medication cart until the next shift came on duty to destroy them with her. *Two nurses had to sign off on the destruction of the schedule II narcotics. 2. Observation on 11/7/13 at 8:55 a.m. of the north medication room revealed: *A brown paper bag underneath the sink that contained multiple bottles of medications. *Upon further review the medications belonged to resident 27. Interview on 11/7/13 at 8:55 a.m. with LPN E revealed had been unsure why resident 27's	F 431		

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F 431	Continued From page 57 medications had been stored under the sink and had not known what they were for. 3. Interview on 11/7/13 at 11:15 a.m. with the director of nursing confirmed: *She would have expected schedule II narcotics awaiting destruction to have been in a separately locked and permanently affixed compartment. *Medications should not have been stored underneath of the sink in the north medication room. *Nothing should have been stored underneath of the sink. Review of the provider's December 2008 Disposal of Medications policy revealed "Medications included in the Drug Enforcement Administration classification as controlled substances or those classified as such by state regulation are subject to special handling, storage, disposal and record keeping in the nursing care center in accordance with federal and state laws and regulations."	F 431		
F 441 SS=E	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,	F 441		

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F 441	Continued From page 58 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 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: 32572 Based on observation, interview, and policy review, the provider failed to ensure: *Safe and sanitary conditions within the building such as commingling of resident supplies with chemicals and uncleanable surfaces within resident rooms. * Appropriate hand washing during one of one observed dressing change for resident (8) by licensed practical nurse (LPN) F. Findings include:	F 441	F441 1a. Each resident's supplies will be placed in separate container, separating hair and oral care items/supplies by December 27, 2013. b. Register fins will be dusted in resident rooms by Maintenance by December 27, 2013. c. In the AACU, Each resident's supplies will be placed in separate container, separating hair and oral care items/supplies by December 27, 2013. The razor and nail clippers will be cleaned with alcohol, following removal of debris by December 27, 2013. The items will be cleaned between each resident's use. d. In the AACU, Each resident's supplies will be placed in separate container, separating hair and oral care items/supplies, with chemicals stored away from the resident's personal items by December 27, 2013. e. Caulking around the toilets in resident rooms 9, 10, 11, 12, 13, 14 will be completed by December 27, 2013 f. The paper towel holder in room #8 will be replaced by December 27, 2013 g. All grab bars in the resident bathrooms will be inspected and replaced if chipped and/or rusted by December 27, 2013 h. The lap buddy will be cleaned and all equipment/supplies cleaned as needed by December 27, 2013	

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F 441	Continued From page 59 1. Random resident room observations from 11/4/13 through 11/7/13 revealed: a. A sampling of resident rooms revealed commingling of supplies in a basket on the edge of the sink. *One of those baskets had personal care supplies, oral supplies, and perfume in the basket (Photo 16). b. Random resident rooms heat registers with dust on the fins (Photo 17 and 18). c. The advanced Alzheimer's care unit (AACU) shower area had commingling of resident supplies with chemicals (Photo 19). *The multiple resident use electric razor had hair and skin debris present in it (Photo 20). *The multiple use resident nail clippers had nail clippings present in it. d. The AACU public restroom in the dining room had commingling of resident care items with chemicals (Photo 21). e. Resident bathrooms (9, 10, 11, 12, 13, and 14) had toilets with dirty caulking or caulking not present (Photo 13, 14, 15, 22, and 23). f. Resident room 8 had a metal paper towel dispenser with chipped paint and rust present making it an uncleanable surface (Photo 24). g. Eleven of thirteen random bathrooms had provider installed grab bars which had rust that made them uncleanable surfaces (Photo 4). h. One of one random lap buddy cushion had dried food debris (Photo 25). Interview on 11/6/13 at 8:30 a.m. with the temporary part time maintenance supervisor from another Golden Living Center confirmed the findings above. He had been working at the facility eight hours a week for the last five weeks. He had been concentrating on the safety issues of the facility.	F 441	The tub/shower cleaning procedure will be posted in each bathing room, to include between residents, daily terminal cleaning and for resident's with infections by December 27, 2013. The mesh covers will be replaced by ABM with non-permeable covers by December 27, 2013 All wheel chairs and lap buddies will be cleaned, with wheel chair and lap buddy cleaning schedule enforced with the nursing department; and all wheel chairs will be audited for cracked and cleanable surfaces by December 27, 2013. There was no corrective action to be taken on resident 8 dressing change. LPN F will be educated by DNS by 12/27/13 regarding proper dressing change procedures, pain management during dressing change, and hand washing. All residents have the potential to be affected. 2. Staff will be educated regarding proper hand washing by 12/5/13. All licensed nurses will be educated regarding dressing changes by 12/27/13. Nursing staff will be educated regarding cleaning of resident care equipment, including razors and nail care products by 12/27/13. All staff will be educated regarding reporting issues and environmental observations to the maintenance department timely by 12/27/13. 3. DNS or designee will audit all items cited weekly x 4 then monthly x 3. Audits will be presented by the DNS or designee to the monthly QAPI committee for review and recommendation.	4.12/27/13

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F 441	Continued From page 60 2. Observation on 11/5/13 of certified nursing assistant (CNA) B in one of one whirlpool tub room revealed she had not cleaned the tub as directed by disinfectant manufacturer. Review of the provider's product details for the above disinfectant (Maxima 128) revealed "Treated surfaces should remain wet for ten minutes." Interview on 11/5/13 at 10:40 a.m. with CNA B confirmed she had not left the disinfectant on the surface of the tub for ten minutes. 3. Observation on 11/6/13 at 9:15 a.m. revealed three of three laundry carts had mesh covers that had allowed water to pass through to the clean clothing. Interview on 11/6/13 at 9:15 a.m. with housekeeping site supervisor and laundry aide A confirmed the laundry cart covers would allow water through to the clean clothing. 4. Observation on 11/7/13 at 8:15 a.m. of AACU wheelchairs revealed: -Five of five were dirty with dried on food particles on them (Photo 26). -One of five had cracked arms on the wheelchair making an uncleanable surface. Interview on 11/7/19 at 8:30 a.m. with the director of nursing (DON) confirmed there was a wheelchair cleaning schedule. She confirmed the schedule had not been followed. She confirmed the above findings had not been acceptable with the infection control program.	F 441		

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F 441	Continued From page 61 Review of the provider's 2001 MED-PASS Infection Control policy revealed "The objective of our infection control policies and practices are to maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public." Surveyor: 32333 5. Observation on 11/6/13 at 10:30 a.m. of licensed practical nurse F while performing a dressing change on resident 8 revealed: *She entered the resident's room. *The resident had been trying to get out of bed. *She helped the resident lay back in bed. *She washed her hands for less than three seconds. *She laid her clean supplies on a paper towel on the resident's bed. *She put on gloves. *The wound had been without a dressing. *She put iodine onto a cotton ball and applied it to the wound. *The resident said "ow." *Applied a two-by-two gauze onto the wound. *She removed her soiled gloves and washed her hands for less than three seconds. *She put on new gloves. *She placed a four-by-four gauze over the two-by-two gauze and secured it with paper tape. *The resident said "ouch." *She put the resident's foot back into her pressure relieving boot. *She removed her gloves and washed her hands for less than three seconds. Interview on 11/7/13 at 11:15 a.m. with the director of nursing revealed she would have expected appropriate handwashing for at least twenty seconds in-between glove changes.	F 441		

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F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on observation, record review, interview, and policy review, the provider failed to ensure the facility was administered in a manner that ensured: *The physician and responsible party had been notified for: -Scratches, scabs, and scarring for one of two sampled residents (5) with a seatbelt physical restraint. -Pain during one of one observed dressing change on one of one resident (8) *Medications were properly administered to one of one randomly observed resident (16). *Two of two sampled residents (5 and 8) with a seat belt had remained free from physical restraints. *The dignity had been maintained for one of three sampled residents (12) and three randomly observed residents (21, 23, and 26) in the advanced Alzheimer's care unit (AACU). *An effective activities program for one of one acute Alzheimer's care unit had been developed, implemented, and maintained. *Housekeeping and maintenance services to the interior building had been maintained in a sanitary manner. *Care plans had been revised and updated for	F 490	F490 Pleases refer to plan of correction for F157, F221, F241, F248, F253, F280, F281, F309, F318, F323, F353, F371, F425, F431, F441, F490, F493, F514, F520. Golden Living Area Vice President (AVP) or designee will perform audits monthly for 3 months of the monthly QAPI committee minutes to ensure that facility is being administered in a manner that enables it to use is resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well being of each resident. Audits will be presented by Golden Living AVP or designee to the monthly QAPI committee for review and recommendation.	12/27/13

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F 490	Continued From page 63 five of twelve residents (1, 4, 5, 8, and 12). *Professional standards had been followed for: -The use of a personal monitor (sounding device) for one of one sampled resident (6). -The use of a sling for one of one sampled resident (4). -The administration of eye drops according to physician's order by one of one licensed practical nurse (LPN) (K) observed during medication pass for one of one sampled resident (8). -Clarification of physician's orders for the administration of an inhaler administered by one of one LPN (K) to one of two residents (17) observed during medication pass. *Necessary services were provided to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care for one of one sampled resident (2) who had spent most of his waking hours in a wheelchair or recliner near the nurse's desk every day. *An effective restorative care program had been maintained in one of one acute AACU, and one of one sampled resident (2) had been appropriately assessed for the need for restorative care. *The facility environment remained free of accident hazards evidenced by: -Two of two residents (18 and 19) from the ACU had not been adequately supervised in the courtyard. -Residents from the ACU had not been prevented unsupervised access to the outside courtyard. -An unsecured Exelon medication patch for one randomly observed resident in the AACU. -An unsecured oxygen tank in one of two medication room. *Appropriate staffing to provide necessary care and services to maintain the highest practicable level of physical and psychosocial well being in	F 490		

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F 490	Continued From page 64 the AACU. *Food was stored, prepared, and served in a sanitary manner. *Outdated medications had been disposed of and not administered to residents in two of two observed medication carts. *Schedule II medications (narcotics) awaiting destruction were stored in a separately locked permanently affixed compartment in one of two observed medication carts. *Medication in one of two medication rooms had been properly stored. *Safe and sanitary conditions had been maintained within the building such as commingling of resident supplies with chemicals and uncleanable surfaces within resident rooms. and during one of one observed dressing change for resident (8) by licensed practical nurse (LPN) F. *Documentation of activities for two of two randomly sampled residents (3 and 4) in the ACU had been completed accurately. Findings include: 1. For the above findings: refer to F157, F221, F241, F248, F253, F280, F281, F309, F318, F323, F353, F371, F425, F431, F441, F490, F493, F514, and F520. 2. Interview on 11/6/13 at 2:10 p.m. with the acting administrator revealed: *She had been instructed by her supervisor that she would be expected to cover the administration duties at the facility. *Those duties had started 8/26/13. *She had been covering the administration at the facility, because the regular administrator had been on maternity leave. *She had spent one day with the administrator	F 490		

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F 490	Continued From page 65 preparing to administrate in her absence. *The administrator from another corporately owned facility was to have assisted covering the administration duties during that time. -He had only been at the facility three times. -Those times had occurred from 8/26/13 through September 2013. *Since 8/26/13 the acting administrator had been coming to the facility weekly for seven hours. *The corporate consultant nurse had been to the facility twice during that time on 8/27/13 and 9/13/13. *She stated she thought the current administrative status of the facility had been doable. "They were surviving." *The planned return of the regular administrator had been on 12/2/13. Review of the provider's Executive Director Administrative Department policy dated 8/30/11 revealed the executive director (administrator) was to have: *Led and directed the overall operations of the facility in accordance with customer needs, government regulations and company policies, with focus on maintaining excellent care for the residents while achieving the facility's business objectives. *Overseen regular rounds to monitor delivery of nursing care, operation of support departments, cleanliness and appearance of the facility and ensure resident needs were being addressed. *Ensured the building and grounds had been appropriately maintained and the equipment and work areas were clean, safe and orderly, and that infection control practices and procedures were followed. *Maintained a working knowledge of compliance with all governmental regulations.	F 490		

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F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on interview, the governing body failed to ensure all areas were effectively administered, policies and procedures were implemented and maintained, and the facility was managed and operated by the professional staff. Findings include: 1. Interview on 11/7/13 at 11:00 a.m. with the administrator revealed she had been uncertain of the governing body's involvement in the management and operation of the facility. She stated she did not report to them but to her supervisor. She had been unaware how they had received and reviewed any information in regards to the facility. Refer to: F157, F176, F221. F241, F248, F253, F280, F281, F309, F312, F318, F323, F353, F 371, F425, F431, F441, F490, F493, F514, and F520.	F 493	F493 Please refer to F490	12/27/13
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		

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F 514	Continued From page 67 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. This REQUIREMENT is not met as evidenced by: Surveyor: 28057 Based on observation, record review, and interview, the provider failed to document activities for two of two randomly sampled residents (3 and 4) in the Alzheimer's Care Unit (ACU). Findings include: 1. Observation and interview revealed resident 3's activities had been documented before they had occurred and had not reflected the resident's actual activity participation. Refer to F248, finding 2. Surveyor: 29162 2. Review of resident 4's November 2013 Daily Recreation Participation Record on 11/6/13 at 10:00 a.m. revealed all his activities had been signed off for that day. Interview with the Alzheimer's care unit director on 11/7/13 at 9:05 a.m. revealed she agreed resident 4's activities had been pre-signed as	F 514	F514 Please refer to F248 regarding documentation of activity before activity occurred.	12/27/13

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F 514	Continued From page 68 having been done. She stated they did have those activities in the morning, but the independent activities should not have been initialed ahead of completion. She stated she had needed to revamp the form to include documentation spaces for morning, afternoon, and evening activities.	F 514	The executive director will be responsible to ensure all training is completed and reported to QAPI. mp/SDOH/MF	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	F520 1. All items and/or issues identified as areas in need of improvement will be outlined on the facility QAPI template to better outline the identified concern, the goals and actions to be taken, and how the effectiveness of these interventions will be monitored. Effectiveness of interventions put in place will be evaluated and presented to the QAPI Committee for review and the interdisciplinary team will determine if interventions have been effective or need revision to meet the stated goals. All residents have the potential to be affected.. 2. All departments will be required to attend training on 12/11/13 regarding development of process improvement plans in response to issues identified within the facility affecting the quality of care provided to the residents. Training will also focus on identifying trends and monitoring effectiveness of interventions put in place to correct the concern. 3. Administrator or designee, will be responsible for seeing that all items are identified through the QAPI process monthly.	4. 12/27/13

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F 520	Continued From page 69 Surveyor: 29162 Based on record review, policy review, and interview, the provider failed to ensure an effective quality assurance (QA) program had been maintained to identify concerns, develop and implement corrective action, and evaluate the effectiveness of plans used for QA. Findings include: 1. Interview on 11/6/13 at 2:25 p.m. with the director of nurses (DON) revealed: *She was the current coordinator of QA. *The QA committee met on a monthly basis. *At that meeting they "look over everything." -Those areas had included pain, medication errors, infection control, call lights, resident concerns, restraints, nutrition, department of health reporting, and what information they had gotten from stand-up meetings. *They approached QA as a team. They had previously focused on areas of concerns such as call lights and narcotic accountability. -The findings of those focus areas had not been tracked or trended. She was unsure of any changes that had occurred because of those focus areas. *Falls had been a focus area of QA. They had identified falls as a concern in the past and had added a float position for awhile. They also had trended falls and had notified the physician if there had been a need for medical care. They would add an activity for the residents if needed to keep them busy. She stated "We added a floater in the summer for awhile." There had been no additional evaluation of falls for the effectiveness of that floater or need for further evaluation. *There currently had not been a specific QA activity in place to monitor and track medication	F 520		

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F 520	Continued From page 70 errors. She had been unsure how many medication errors there had been in the recent months. 2. Review of the undated "Total Falls" report received from the provider on 11/8/13 via a five page facsimile revealed: *From page two the total number of falls had been seventeen. That had been up from fourteen. -The review and documentation portion on that fall report had revealed there had been a "frequent faller related to disease and medication regimen times 2". *From page three the total number of falls had been fourteen. That had been down from twenty. -The review and documentation portion of that fall report had revealed there had been a frequent faller related to _____ (specific diagnosis). There had been a frequent faller with noted post medication changes for seizure activity and increased behaviors. There had been one fall with a fracture. *From page four the information had been identical to page three. *From page five the total number of falls had been twenty. That had been up from fifteen. -The review and documentation of the fall report revealed there had been three frequent fallers. *That form had only revealed the problems. There had been no mention of goals, changes, or actions to correct the problems. -There had been a column headed "Analysis of opportunities identified and actions taken." -That column was where the concerns and events had been recorded. -There had been no documented actions. *There had been no current QA activity in place to evaluate falls. They had only been reported by the DON at QA meetings.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435054		11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 71 3. Review of the undated Event Reporting report received from the provider on 11/10/13 via seven page facsimile revealed: *From page two, "Noted 3 medication errors this month, which is the same from last month". There had been no trends noted for any allegations of abuse or neglect. *From page three, "Noted 3 medication errors this month, which is up from 2". There had been one missing funds identified for allegations of abuse or neglect. *From page four, "Noted 2 medication errors this month". *From page five, "Noted Med Error improvement with the new EMAR/ETAR system." An "elopement of a resident was reported to DSS, ombudsman and DOH." *That Event Reporting form had only revealed the problems. There had been no mention of goals, changes, or actions to correct the problems. -There had been a column headed Trending Analysis of Opportunities. -That column is where the concerns and events had been recorded. -There had been no documented actions or analysis of the events. *There had been no current QA activity in place to evaluate medications errors. They had only been reported by the DON at QA meetings 4. Interview on 11/7/13 at 11:30 a.m. with the activity director revealed her part of QA had been to enter the resident council concerns. She had attended the QA meetings. She stated at one meeting she had brought up a concern of soiled wheelchairs. She stated she did not think there had been any monitoring or auditing done. They had ordered new brushes. She stated she felt the	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	435054		11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 72 wheelchairs were still not very clean, but QA had not pursued evaluating this concern. Interview on 11/7/13 at 1:00 p.m. with the director of clinical education revealed she had not been currently completing any monitoring or review of the nurses and medication passes for QA. Usually after a nurse made a medication error she reviewed the educator's medication pass sheets with them. She tried to do a competency of each nurse at least once every four months. She had completed the medication pass competency with the night nurses at least annually. Review of the provider's revised 2013 quality assurance performance improvement (QAPI) Committee Guideline (QA) revealed: *The committee oversaw the quality and effectiveness of living center operations and systems to meet the needs of the customers. *The committee evaluated facility progress toward improvement and coordinated process improvement activities. *The facility conducted "Performance Improvement Projects (PIP)" to examine and improve care or services identified as having needed attention. *The PIP project had been a concentrated effort on a particular problem area of the facility or facility wide. It involved gathering information systematically to clarify issues or problems and intervening for improvements.	F 520		

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

ORIGINAL

PRINTED: 11/12/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/05/13. Golden LivingCenter - Redfield (building 01) 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 deficiencies identified at K025, K050, K062, and K144 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 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.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the 30 minute fire-resistive rating of smoke barrier walls for one of two smoke barrier walls. The south side of the south	K 025	K025 1. a. Smoke barrier penetrations for the south wing were sealed with flame retardant silicone on November 8, 2013, [redacted] *CH/SDDOH/MF b. Smoke barrier penetrations above the lay-in ceiling were sealed with flame retardant silicone on November 8, 2013, [redacted] *CH/SDDOH/MF 2. All smoke barriers will be checked by the Maintenance Director or designee for penetrations and the penetrations sealed by 12/27/2013. 3. Smokes barriers will be examined by the Maintenance Director or designee, for penetrations following contractor work involving any smoke barrier walls. Completion of the checks (#2 above) of all smoke barriers will be reported to the QAPI committee.	4. 12/27/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Rude	ED	12/4/13

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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DEC 05 2013
SD DOH L&C

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
	435054		**11/05/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 1 smoke barrier wall had an unsealed penetration around wiring above the lay-in acoustical ceiling on the east end of the wall. Findings include: 1. Observation at 2:00 p.m. on 11/05/13 revealed the south side of the smoke barrier wall (adjacent to therapy) for the south wing had a six inch diameter unsealed wiring penetration above the lay-in acoustical ceiling in the east end of the wall. Interview with the maintenance director at the time of the observation confirmed that finding.	K 025		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure all staff were familiar with fire drill procedures. Findings include: 1. Observation at 3:15 p.m. on 11/05/13 revealed the nurse responding to the simulated fire did not pull the resident room door closed to isolate the effects of the fire. After removing the resident from the room she asked the maintenance director if she should pull the manual fire alarm	K 050	K050 1. No resolve for the staff action re: immediate correction 2. All facility staff will participate in education for Fire Drills by [redacted] * 12/27/13 CH/DOH/MF 3. Fire Drills will be performed by Maintenance Director or designee until compliance is achieved and required schedules for fire drills will be followed/completed. The Maintenance Director or designee will report the outcome of the fire drills to the QAPI committee for 3 months or until compliance is achieved.	4. 12/27/13

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
	435054		**11/05/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 located in the corridor next to the room. Interview with the maintenance director at the time of the observation confirmed that finding. He stated the nurse had been an employee at the facility for the previous two years.	K 050		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector so the water discharge was not interrupted for one randomly observed sprinkler in resident room 17 closet. Findings include: 1. Observation at 10:45 a.m. on 11/05/13 revealed a sprinkler in the resident room 17 closet was obstructed by blankets on the top shelf. The closet had a 3/4 inch thick full depth plywood divider between the two residents' lower halves of the closet. That obstructed the sprinkler pattern to the opposite lower side of the closet. Interview with the maintenance director at the time of the observation confirmed that finding.	K 062	K062 1 a. The blankets from Room 17 closet shelf were removed on November 8, 2013 b. The plywood divider in Room 17 will be reconstructed by the Maintenance Director or designee, to allow adequate sprinkler coverage to both sides of the closet by 12/27/2013. 2. All resident closets were inspected, by the Maintenance Director personnel , to ensure all personal belonging and closet dividers allow adequate sprinkler coverage. Closet repairs will be contracted by 12/27/2013. Staff will be educated regarding the sprinkler system/sprinkler head clearance distances, resident personal belonging storage near sprinkler heads. 3. An audit of the resident's closet, sprinkler head clearance, will be performed monthly by the Maintenance Director or designee and reported to the QAPI Committee for x 3 months or until compliance is achieved.	4.12/27/13
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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
	435054		11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain an emergency battery powered lighting unit at the transfer switch location in the boiler room for one of one emergency lights. The battery powered back-up light did not work when tested. Findings include: 1. Observation and testing at 11:45 a.m. on 11/05/13 revealed the provider failed to maintain an emergency battery powered lighting unit at the transfer switch location in the boiler room. The battery powered back-up light did not work when tested. Interview with the maintenance director at the time of the observation confirmed that finding.	K 144	K144 1. The emergency battery powered lighting unit at the transfer switch in the boiler room was repaired on November 13, 2013. 2. All emergency battery powered lighting units in the facility were function tested by the Maintenance Director or designee on 11/26/2013. Completed the monthly preventative maintenance (PM) checks, in Building Engines, for the emergency battery powered lighting units in the facility on 11/25/13. 3. The Administrator or designee will perform random checks of the PM checks monthly x 3 to ensure completion. The Maintenance Director or designee will report the emergency light PM checks to the QAPI Committee monthly x 3 months	4. 12/27/13

ORIGINAL

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

PRINTED: 11/12/2013
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	435054		11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/05/13. Golden LivingCenter - Redfield (Building 02) 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 deficiencies identified at K038 and K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure exits were readily accessible at all times. Two of three magnetically locked exit doors from the advanced Alzheimer's care unit (AACU) did not release and open upon activation of the fire alarm system. Findings include: 1. Observation and testing at 3:15 p.m. on 11/05/13 revealed the north exit door from the AACU and the gate from the courtyard were	K 038	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. K038 1. The magnetic lock at the north exit door from the AACU will be repaired to facilitate opening properly with the fire alarm on 12/3/13. 2. The Maintenance Director or designee checked all magnetic door locks to ensure proper function/operation during a fire drill on 11/26/13. The Maintenance Director or designee will perform magnetic door lock checks with each fire drill. All staff will be educated regarding the magnetic door lock function by 12/27/13.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Rude	SD	12/24/13

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	435054		11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 equipped with magnetic locks. Testing of those doors during the audible fire drill revealed they did not release upon activation of the fire alarm. The third door with a magnetic lock (in the corridor between the aacu and the Alzheimer's care unit (ACU) did release when tested during the drill. Interview with the maintenance director at the time of the observation confirmed that finding. He stated the magnetic door locks were to be tested by staff during fire drills and noted on the documentation form after the drill.	K 038	3. Fire drills, including magnetic door lock function, will be reported to the QAPI Committee by the Maintenance Director or designee monthly x 3 months or until compliance is achieved.	4. 12/27/13
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to ensure all staff were familiar with fire drill procedures. Findings include: 1. Observation at 3:15 p.m. on 11/05/13 revealed the nurse responding to the simulated fire did not pull the resident room door closed to isolate the effects of the fire. After removing the resident from the room she asked the maintenance director if she should pull the manual fire alarm	K 050	K050 1. No resolve for the staff action re: immediate correction 2. All facility staff will participate in education for Fire Drills by December 27, 2013. 3. Fire Drills will be performed by Maintenance Director or designee until compliance is achieved and required schedules for fire drills will be followed/completed. The Maintenance Director or designee will report the outcome of the fire drills to the QAPI committee for x 3 months or until compliance is achieved.	4.12/27/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED
	435054		11/05/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 located in the corridor next to the room. Interview with the maintenance director at the time of the observation confirmed that finding.	K 050		

ORIGINAL

PRINTED: 11/20/2013
FORM APPROVED

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
	10671		11/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 11/04/13 through 11/07/13. Golden LivingCenter - Redfield was found not in compliance with the following requirements: S130, S156, and S194.	S 000		
S 130	44:04:02:06 FOOD SERVICE Food service must be provided by a licensed facility or food establishment that is inspected by a local, state, or federal agency. The facility must meet the safety and sanitation procedures for food service in chapters 44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher must be provided in all facilities of 20 beds or more. The facility must have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the integrity of the building to prevent contamination of food and food preparation surfaces in the advanced Alzheimer's care unit (AACU) and the main kitchen. Two of two 25 watt incandescent lamps over the stove were not shatterproof or were not equipped with covers. The grease filters in the main kitchen range hood had lint buildup.	S 130	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. S130 FOOD SERVICE 1a. The two incandescent lamps over the stove in AACU were replaced or covered with shatter proof bulbs on 11/27/13. b. The grease filters for the main kitchen range hood were cleaned on November 8, 2013. 2a. The Maintenance Director or designee will check all unprotected incandescent lamps to ensure they are shatter-proof or covered by 12/27/13 b. The range hood filter cleaning is included in the Preventative Maintenance program to be completed monthly 3. The Maintenance Director or designee will be educated in the Preventative Maintenance program for the facility. The Administrator will audit the preventative maintenance documentation monthly x 3. An audit of the incandescent lamps and PM checks of the range hood will be reported to the QAPI committee monthly x 3 or until compliance is achieved.	4.12/27/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Rude

TITLE: ED

(X6) DATE

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DEC 05 2013
SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10671	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 130	Continued From Page 1 Findings include: 1. Observation at 2:30 p.m. on 11/05/13 revealed two 25 watt incandescent lamps over the stove in the AACU were not shatterproof or were not equipped with covers. Interview with the maintenance director at the time of the observation confirmed that finding. 2. Observation at 2:45 p.m. on 11/05/13 revealed the grease filters for the main kitchen range hood had lint buildup. Interview with the maintenance director at the time of the observation confirmed that finding. He stated the kitchen hood was cleaned in-house quarterly. He was not sure how often the grease filters were cleaned beyond that schedule.	S 130		
S 156	44:04:02:12 VENTILATION Electrically powered exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain exhaust fan ventilation in one randomly observed room (the public unisex restroom in the main lobby). Findings include: 1. Observation and testing at 2:45 p.m. on 11/05/13 revealed the continuous mechanical	S 156	S156 VENTILATION 1. The exhaust fan in the public unisex restroom in the main lobby was replaced on November 13, 2013. 2. The Maintenance Director or Designee will inspect all exhaust fans to ensure proper function by 12/27/2013 3. The Maintenance Director or Designee will complete the monthly Preventative Maintenance (PM) checks of exhaust fans. The Administrator or designee will perform random checks of the preventative maintenance program completion monthly x 3. The Maintenance Director will report the PM checks to the QAPI committee monthly x 3 or until compliance is achieved.	4.12/27/13

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10671	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 11/07/2013
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 156	Continued From Page 2 exhaust fan was not working in the public unisex restroom in the main lobby. Testing of that exhaust vent did not show any negative pressure when covered with a sheet of toilet paper. Interview with the maintenance director at the time of the testing confirmed that finding. He stated several other exhaust fan motors had recently been replaced. That room had not yet been checked to determine if the exhaust fan was working.	S 156		
S 194	44:04:03:01 Fire Safety Code Requirements Each facility...must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2000 edition. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the heating equipment for one of two boilers for the facility. One boiler did not have an inspection certificate. Findings include: 1. Observation at 11:15 a.m. on 11/05/13 revealed one of two boilers in the boiler room had an inspection certificate. The Rheem/Ruud/Universal brand 250,000 British thermal units/hour input boiler (water heater style) was fed with natural gas and did not have an inspection certificate. The name plate data indicated the boiler had been manufactured in April 2012. Interview with the maintenance director at the time of the observation revealed no record could be found of the installation. He stated the boiler must have been installed sometime during the past twelve months.	S 194	S194 FIRE SAFETY 1. The boiler inspection will be completed by 12/27/13. 2. This issue will be resolved upon completion of the annual boiler inspection. 3. The Maintenance Director will ensure annual inspections and supporting documentation is completed as required, tracking the inspection through the Preventative Maintenance (PM) program. The Administrator will monitor the PM programs to ensure compliance and completion. The Maintenance Director will report the completion of the inspection to the QAPI committee.	4.12/27/13