

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

ORIGINAL

PRINTED: 01/06/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/31/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - REDFIELD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 THIRD STREET EAST REDFIELD, SD 57469</b>
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{F 000}	INITIAL COMMENTS  Surveyor: 29162 A recertification health survey revisit for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/30/13 through 12/31/13. Golden LivingCenter-Redfield was found not in compliance with the following requirements: F221, F318, and F441.	{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.  <b>F221</b>  1. An order to discontinue the restraint for resident 8 was received on 1/7/14. The restraint was removed from residents chair on 1/7/14. Therapy will evaluate and treat resident for fall prevention strategies.  Orders to discontinue the restraint for resident 28 were received on 12/31/13, the seatbelt was removed from her wheelchair on 1/7/14. Therapy will evaluate and treat resident for fall prevention strategies.  An audit of all residents who have used restraints was conducted on 1/6/14, no restraints in use as of 1/6/14.  2. Nursing staff will be educated by 1/17/14 regarding the facility restraint utilization guideline.	
{F 221}	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS D mpls000H/JS 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 guideline review, the provider failed to ensure one of two residents (8) identified as having a seat belt physical restraint in the 11/7/13 survey and one of five sampled residents (28) had remained free from physical restraints in the acute Alzheimer's care unit (AACU) by the plan of correction dated 12/27/13. Findings include:  1. Observation on 12/30/13 at 2:15 p.m. of resident 8 in the AACU dayroom revealed she had been sitting in her wheelchair with her head down. Her eyes were closed and a seat belt physical restraint had been around her waist.  Review of resident 8's 12/22/13 physician's orders revealed an as needed (PRN) seat belt	{F 221}		

*Addendums noted with an asterisk per 01/14/14 telephone to facility administrator mpls000H/MS*

*\*No PRN resident restraints were in use as of 01/06/14 at the time of the audit. An order to discontinue resident 8's prn restraint was then obtained on 01/07/14. mpls000H/MS*

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

JAN 15 2014  
If continuation sheet Page 1 of 12  
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{F 221}	<p>Continued From page 1</p> <p>physical restraint when interventions of toileting, offering food/snack, one-to-one visiting, evaluation of pain were non-effective for restlessness. That had been related to a diagnosis of dementia and an inability to understand physical deficits and safety issues.</p> <p>Review of resident 8's December 2013 treatment administration record (TAR) revealed: *A PRN seat belt 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 an inability to understand physical deficits and safety issues. *The above seat belt physical restraint had not been documented as having been used in the entire month of December.</p> <p>Review of resident 8's 12/10/13 restraint/positioning device assessment revealed she had been unable to remove the seat belt on command.</p> <p>Review of resident 8's current care plan revealed: *A revised intervention on 3/27/13 for a PRN seat belt 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 an inability to understand physical deficits and safety issues as needed. *12/26/13 "Resident applies seat belt independently and removes at times will monitor."</p> <p>Review of resident 8's 12/4/13 quarterly Minimum Data Set assessment revealed a brief interview for mental status (cognitive assessment) score of 3 indicating severe cognitive impairment.</p>	{F 221}	<p>3. Director of Nursing Services (DNS) or designee will audit any residents who use restraints to ensure proper assessment and documentation is being completed when restraints are used. Audits will be completed weekly for 4 weeks then monthly for 2 months. Results of these audits will be presented by the DNS to the monthly Quality Assessment and Performance Improvement (QAPI) committee for review and recommendation.</p> <p>4. 1/24/14</p>	1/24/14

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{F 221}	<p>Continued From page 2</p> <p>2. Observation on 12/30/13 at 2:15 p.m. of resident 28 in the dining room revealed she had a lap buddy (a flat cushion that fits over a person's lap and under the armrests of a wheelchair or chair) physical restraint on.</p> <p>Review of resident 28's 11/27/13 physician's order revealed "Use a lap buddy device for the patients safety." That order had not been clarified to include when or how often to use the device.</p> <p>Review of resident 28's December 2013 progress notes revealed she had removed her lap buddy and had fallen four times between 12/11/13 and 12/15/13.</p> <p>Review of resident 28's November and December 2013 TAR revealed:                      *No order for a lap buddy physical restraint in November.                      *An order for a "PRN seat belt" from 11/27/13 through 12/14/13. She had no physician's order for a seat belt physical restraint.                      *From 12/14/13 through 12/31/13 the resident could have a PRN lap buddy 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 an inability to understand physical deficits and safety issues as needed.                      *Between 12/14/13 through 12/31/13 the lap buddy had been signed off as having been used two times on 12/26/13 and 12/30/13.</p> <p>Interview on 12/30/13 at 5:40 p.m. with the AACU director revealed resident 28 had the lap buddy physical restraint on since 11/27/13 anytime she was up in her wheelchair.</p>	{F 221}		

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{F 221}	Continued From page 3  3. Review of the provider's plan of correction with a completion date of 12/27/13 from the 11/7/13 survey revealed all residents including the above who use restraints had the appropriate assessment and documentation for the use of a restraint.  Interview on 12/30/13 at 5:20 p.m. with licensed practical nurse K revealed: *She had signed resident 28's TAR that her lap buddy had been on at 3:17 p.m. when she noticed it was on the resident. *The aides had put resident 28's lap buddy on without informing her. *She had not noticed resident 8's seat belt had been on, so she had not signed it as being on. *Resident 8 sometimes played with her seat belt and put it on by herself.  Interview on 12/31/13 at 2:00 p.m. with the administrator and director of nursing confirmed: *Licensed nursing staff should have been evaluating the use of restraints and documenting them. *Resident 8 would sometimes incorrectly apply her seat belt by herself when she was playing with it.  Review of the provider's revised 2013 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 to purposes of discipline or convenience or when not required to treat the resident's medical symptoms. The least restrictive device will be used."	{F 221}			

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{F 221}	Continued From page 4 *"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." *"The restraint is to be checked as frequently as needed in accordance with the resident's needs." *"Residents who have physical restraints are to be reevaluated quarterly or more often as directed by the needs of the resident. This evaluation is to focus on the potential for reduction and elimination based upon resident specific information and findings."	{F 221}			
{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 record review, interview, and policy review, the provider failed to ensure an effective	{F 318}	<b>F318</b>  1. A restorative staff position was posted on 1/2/13. A staff person has been assigned to provide restorative nursing services to all residents with orders for restorative nursing until a dedicated restorative staff person is hired. There is no corrective action to be taken regarding the blank spaces or lack of documentation for restorative nursing provided to residents 23 and 28.  Orders have been received for residents 8 and 28 to be evaluated and treated by therapy.  2. Nursing staff will be educated by 1/17/14 regarding the provision of services to maintain an effective restorative nursing care program.  3. Restorative nurse or designee will audit restorative programs and documentation for 5 residents who have orders for restorative nursing to ensure that an effective restorative care program is being maintained. Audits will be completed weekly for 4 weeks, then monthly for 2 months. Results of these audits will be presented by the restorative nurse to the monthly QAPI committee for review and recommendation.  4. 1/24/14	1/24/14	

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{F 318}	<p>Continued From page 5</p> <p>restorative care program had been maintained for two of two sampled residents (23 and 28) in one acute Alzheimer's care unit. Findings include:</p> <p>1. Review of resident 23's 12/18/13 physician's orders revealed: *Passive range of motion (PROM): complete to upper extremities. Complete two times a day (BID), up to seven days per week. Goal: maintain upper extremity range of motion (ROM) and functional positioning. Two times a day.</p> <p>Review of resident 23's December 2013 restorative record revealed: *PROM: complete to upper extremities. Complete BID, up to seven days per week. Goal: maintain upper extremity ROM and functional positioning. *Multiple blank spaces that had not been signed as completed. *No other documentation that restorative care had been offered.</p> <p>2. Review of resident 28's December 2013 restorative record revealed: *Ambulation: ambulate in hallways 200 feet or as tolerated. Complete up to seven days per week. Goal: maintain ability to ambulate every day and evening shift. *Multiple blank spaces that had not been signed as completed. *No other documentation that restorative care had been offered. Refer to F221, finding 2.</p> <p>3. Interview on 12/31/13 at 11:40 a.m. with the restorative care nurse revealed she would have expected restorative care to have been offered and documented seven days per week.</p>	{F 318}			

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{F 318}	Continued From page 6 4. Interview on 12/31/13 at 2:00 p.m. with the director of nursing and the administrator revealed: *Restorative care had not been getting done due to a shortage in staffing. *They had several registry (temporary agency) staff at this time.  Review of the provider's revised 2013 Restraint Evaluation and Utilization Guideline revealed: **"Providing restorative care to enhance abilities to stand, transfer, and walk." *Example of alternative interventions to restraints include the use of rehabilitative/restorative care.	{F 318}		
{F 441} SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	{F 441}	<b>F441</b>  1. CNA S was educated on 12/30/13 regarding the proper procedure for cleaning the tub and shower areas.  LPN E was educated on 1/3/14 and LPN F was educated on 1/7/14 regarding the proper procedure for dressing change.  Nursing staff will be educated by 1/17/14 regarding proper procedure for completion of a dressing change.  On 1/6/14 an audit of multiple use razors was completed. The razor used for multiple residents in the AACU bathroom was removed on 1/8/14. Residents will have their own razors and multiple use razors will be removed by 1/8/14.  The chemicals noted to be stored with personal care items in 2 AACU bathrooms were removed immediately. Cabinets to provide separate storage of chemicals and personal care items will be in place by 1/24/14.  Maintenance personnel caulked around the toilets in rooms 3, 4, 9, 10, 13 and 14 on 1/1/14.  The under sink areas in rooms 13 and 15 will be repaired by 1/24/14.  The metal door frame between the AACU and the ACU was painted on 12/31/13.	

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{F 441}	<p>Continued From page 7</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32333 Based on observation, interview, and policy review, the provider failed to ensure: *One of one shower room had been sanitized properly between residents in the acute Alzheimer's care unit (AACU) by one of one observed certified nursing assistant (CNA) (S). *One of one resident's (8) observed dressing had been changed properly by two of two licensed practical nurses (LPN) (E and F). *One of one razor in the AACU dining room bathroom used for multiple residents had been maintained in a sanitary manner. *Chemicals in two of two AACU bathrooms had been stored appropriately. *Toilets had been caulked in resident rooms 3, 4, 9, 10, 13, and 14 (had been identified in the 11/7/13 survey) by the plan of correction dated 12/27/13. *Uncleanable wet, stained, and raw wood surfaces under resident room sinks 13 and 15 (had been identified in the 11/7/13 survey) had</p>	{F 441}	<p>2. Education will be provided to nursing staff regarding the proper procedure for cleaning the tub and shower areas.</p> <p>Education will be provided to staff regarding the infection control procedure for proper cleaning of a razor by 1/17/14.</p> <p>Education will be provided to staff regarding infection control and safety practices pertaining to secure and separate of storage for chemicals and personal care items by 1/17/14.</p> <p>An audit of all toilets in residents rooms will be completed by 1/24/14 to ensure that caulking is in place.</p> <p>An audit of all under sink areas in resident rooms will be completed by 1/24/14.</p> <p>3. DNS or designee will audit tub and shower cleaning procedures weekly for 4 weeks then monthly for 2 months.</p> <p>DNS or designee will audit dressing change procedure with 3 nurses per audit to ensure infection control expectations are met. Audits will be completed weekly for 4 weeks then monthly for 2 months.</p> <p>DNS or designee will perform audit of storage of chemicals and personal care items in each of the bath areas to ensure separation of storage of personal care items and chemicals and ensure chemicals are stored in a secure manner.</p>	

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{F 441}	Continued From page 8 been finished to maintain a cleanable surface by the plan of correction dated 12/27/13. *One metal door frame between the acute Alzheimer's care unit and Alzheimer's care unit with chipped and peeling paint had been painted (had been identified in the 11/7/13 survey) by the plan of correction dated 12/27/13. Findings include:  1. Observation and interview on 12/30/13 at 2:40 p.m. with CNA S while he cleaned the shower in-between residents revealed: *There had been several brown spots on the shower room floor. *The CNA confirmed the brown marks were fecal (stool) matter. *He sprayed the floor with water. *He obtained a towel and placed it on the floor. He used his foot to clean the stool off the floor with that towel. *He sprayed Cen-kleen on the stool. *He again wiped the stool off the floor with the towel using his foot. *He had not cleaned the entire shower floor or the shower walls. *A shower chair had been in the shower, and he had not cleaned the shower chair. *He confirmed he had not been trained at this facility on how to clean the shower. *He then went to get the next resident scheduled for a shower.  Review of the provider's undated Tub and Shower Cleaning policy revealed: **"Sanitize the shower walls, floor and equipment by saturating the entire area with the sanitizing spray." **"The sanitizing solution must remain wet and in place for 10 minutes to achieve adequate	{F 441}	Administrator or designee will audit 5 resident toilets to ensure that caulking is in place. Audits will be completed weekly for 4 weeks then monthly for 2 months.  Administrator or designee will audit under sink area in 5 resident rooms to ensure they are in good repair. Audits will be completed weekly for 4 weeks then monthly for 2 months.  Administrator or designee will audit 5 door frames to ensure they are in good repair. Audits will be completed weekly for 4 weeks then monthly for 2 months.  Results of these audits will be presented by above identified personnel to the monthly QAPI committee for review and recommendation.  4. 1/24/14	1/24/14	

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{F 441}	<p>Continued From page 9 sanitation."</p> <p>2. Observation on 12/31/13 at 10:55 a.m. of LPN E and F performing a dressing change on resident 8 revealed: *Three bags of stock items and multiple biohazard bags had been layed on the resident's bed. *Those bags contained multiple stock items including tape, Coban, Kerlix, and other dressing change materials. *LPN F held the residents foot up while LPN E performed the dressing change. *LPN E removed the old dressing and applied the new dressing. -She then wrapped the resident's dressing and ankle with Coban. She had been using the same gloves she had used to apply the dressing. -She wrapped the roll of Coban around the resident's ankle and foot several times. -She cut the Coban and placed it into the bag of clean stock supplies. -She took the three bags of stock supplies and extra biohazard bags back to the room in which they had been stored.</p> <p>3. Observation on 12/30/13 at 2:20 p.m. in the AACU bathroom off of the dining room revealed a multiple resident use men's electric razor that was full of hair and skin debris.</p> <p>4. Observation on 12/30/13 between 2:15 p.m. and 2:40 p.m. in the AACU revealed: *In the bathroom off of the dining room with the door opened: -Oasis 146 multi-quatarnary disinfectant cleaner had been stored in an unlocked cabinet on a shelf with multiple residents' personal care items including hair brushes and combs.</p>	{F 441}		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435054</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>12/31/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - REDFIELD</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1015 THIRD STREET EAST REDFIELD, SD 57469</b>		
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{F 441}	<p>Continued From page 10</p> <p>-Multiple residents had been wandering near that bathroom.</p> <p>*In the shower room with the door opened:</p> <p>-Maxima disinfectant cleaner and Cen-kleen disinfectant cleaner had been stored in a cabinet with multiple residents' personal care items including shampoos and body washes.</p> <p>5. Interview on 12/31/13 at 2:00 p.m. with the director of nursing and the administrator confirmed:</p> <p>*The shower room in the AACU should have been properly sanitized and disinfected between each resident shower.</p> <p>*The mens electric razor in the AACU dining room bathroom should have been cleaned after each resident use and maintained in a sanitary manner.</p> <p>*Chemicals should not have been unlocked or stored with resident personal care items.</p> <p>Surveyor: 29162</p> <p>6. Observation on 12/30/13 at 4:00 p.m. revealed:</p> <p>*There was no caulking around the toilets in residents' rooms 3, 4, 9, 10, 13, and 14. That caulking was to have been applied by 12/27/13 according to the plan of correction from the survey of 11/7/13.</p> <p>*There were wet and stained areas under the sinks in residents' rooms 13 and 15. Some of the wood had been unfinished and not cleanable. That wet and stained wood was to have been fixed according to the plan of correction from the 11/7/13 survey.</p> <p>*The metal door frame between the AACU and ACU had chipped and peeling paint. That area was to have been painted by 12/27/13 according to the plan of correction from the survey of</p>	{F 441}		

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{F 441}	Continued From page 11 11/7/13.  Observation and interview on 12/31/13 at 1:30 p.m. with the administrator revealed she agreed the: *Toilets in residents' rooms 3, 4, 9, 10, 13, and 14 had not been caulked. She stated the corporate maintenance director had told her not to caulk the toilets. *Areas under the sinks in residents' rooms 13 and 15 were wet and stained. *Area on the metal door frame between the AACU and ACU had not been painted on 12/30/13 when the revisit started.	{F 441}		