

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451
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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
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/22/14 through 4/24/14. Golden LivingCenter - Ipswich was found not in compliance with the following requirements: F241, F248, F280, F281, F309, F327, and F441.	F 000	<p><i>Addendums noted with an asterisk per 6/13/14 telephone to facility administrator. DK/RODOH/ME</i></p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>F241 Dignity and Respect of Individuality</p> <ol style="list-style-type: none"> Residents #4, #13, #14, and #15 were shaved on 4/24/14. Resident 18 was assisted to change his clothing on 4/22/14. LPN A was educated on 5/14/14 regarding a residents rights and dignity as it pertains to assisting a resident to maintain personal hygiene. All residents have to potential to be effected by this practice. Nursing staff will be educated by 6/11/14 that residents need to be shaved daily and that soiled clothing needs to be changed immediately, with resident approval. Director of Nursing Services or designee will randomly audit all residents to ensure residents are shaved and clothing is clean. Audits will be completed bi-weekly for 4 weeks then monthly for 3 months. Results of these audits will be presented by the DNS or designee to the monthly Quality Assessment and Performance Improvement (QAPI) committee for review and recommendation. <p><i>*An informative binder listing residents on isolation precautions, and isolation protocols associated with resident 5, was placed at the nurse's station on 5/14/14. 5/29/14</i></p>	
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: 32355 Based on observation, interview, and policy review, the provider failed to ensure dignity of residents was maintained for: *Four of seven randomly observed residents (4, 13, 14, and 15) who were unshaven. *One of one observed resident (18) who had worn soiled clothes with blood on them to the supper meal. Findings include: 1. Random observations from 4/22/14 through 4/23/14 of resident 4 revealed long, gray, and white facial hair on her chin. During that time frame her facial hair had not been removed or shaved. Interview on 4/23/14 at 3:20 p.m. with resident 4	F 241		

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

[Signature]

EXECUTIVE DIRECTOR
[Signature]
DATE: 5/29/14

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 30 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 241	<p>Continued From page 1</p> <p>revealed she had not realized she had long facial hair on her chin. She would have liked to have the hair shaved off. No staff members had mentioned shaving her chin. Her significant change in status Minimum Data Set (document containing residents' care information) dated 4/1/14 reflected she required set-up help and cueing from the staff to assist with personal hygiene.</p> <p>2. Random observations from 4/22/14 through 4/23/14 of residents 13, 14, and 15 revealed rough, black, and gray facial hair on their upper lips, chins, and cheeks. During that time frame their facial hair had not been removed or shaved.</p> <p>3. Interview on 4/23/14 at 10:45 a.m. with certified nursing assistant (CNA) E revealed both men and women should have been shaved daily in the morning if it was needed.</p> <p>Interview on 4/24/14 at 8:10 a.m. with the director of nursing (DON) revealed she would have expected the residents to be shaved daily. The staff should have been observant of the residents and their shaving needs.</p> <p>Review of the provider's 2006 Shaving the Resident policy revealed the purpose was to remove the resident's facial hair and improve the resident's appearance and morale. The policy had not mentioned how often the resident's facial hair should have been removed.</p> <p>4. Observation on 4/22/14 at 5:10 p.m. of resident 18 revealed: *He had been sitting in a wheelchair (w/c) in his room. *There had been a moderate amount of blood dripping from a scabbed area on the tip of his</p>	F 241		

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F 241	<p>Continued From page 2 nose. *The blood was on his face, all over his hands, down the front of his shirt, and on his left pant leg. *Licensed practical nurse (LPN) A had entered his room to assist him with the blood drippings from his nose. *She had taken a hand towel and attempted to clean off the blood from all of the areas mentioned above. *After attempting to clean off all the areas of the blood LPN A took him out of his room without having his clothes changed. She had placed him in the lobby area across from the nurses' station. *His shirt and pants were dirty and stained with the blood drippings. *In the lobby area had been several unidentified residents going to the dining room for supper. *At 5:30 p.m. he was taken to the dining room by a staff member for the supper meal. *He had been placed at a table with other residents to eat his supper. *No staff members had been witnessed asking him if he would like to have his clothes changed.</p> <p>Interview on 4/24/14 at 8:15 a.m. with the DON revealed the resident should have had his clothes changed prior to bringing him out of his room.</p> <p>Review of the provider's October 2009 Residents' Rights and Dignity policy revealed: **"All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." ***"Treating residents with dignity and respect maintains and enhances each resident's self-worth and improves his or her psychosocial well-being and quality of life."</p>	F 241		

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F 248 F 248 SS=D	Continued From page 3 483.15(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: 33488 Based on observation, interview, and record review, the provider failed to have activities for one of one resident (1) who was bedbound. Findings include: 1. Observations on 4/22/14 at 2:25 p.m., 4:30 p.m., and 6:00 p.m., and on 4/23/14 at 8:05 a.m. of resident 1 revealed: *She was in her room lying in bed. *Staff would come in every two hours to reposition her. *She had no in-room activities for stimulation like a TV or radio. The only sound had been from the oxygen concentrator machine (gave the resident oxygen). *The only light in her room had been partial sunlight from the window. *She cried to this surveyor for water and complained of pain when staff repositioned her. Interview on 4/23/14 at 9:00 a.m. with the activities director revealed: *She had been fairly new to her position. *She admitted she was "bad at documenting activities." *Since the resident had been bedbound, she had	F 248 F 248	F248 Activities Meet Interests/Needs of Each Res 1 Resident 1 was provided with radio to listen to on 4/24/14. There is no further corrective action to be taken for resident 1 as she passed away on 4/26/14. The care plans for all dependent residents were audited to ensure the presence of individualized activity programming, activity documentation is complete and the residents room provides for in room activity and lighting for stimulation. 2. All residents have the potential to be effected by this practice. 3. Activity Director was educated on 5/14/14 regarding need for dependent residents to have an individualized activity plan, activity documentation requirements and the policy and procedure for providing activity to dependent residents. 4. Social Services Coordinator or designee will randomly audit 5 resident activity logs for completion, activity care plans for individualized activity programming, resident rooms for in room activity and lighting for stimulation. Audits will be completed weekly for 4 weeks, then monthly for 3 months or until all residents have been audited. Results of these audits will be presented to the monthly QAPI committee by the Social Services Coordinator or designee for review and recommendation.	6/13/14

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F 248	Continued From page 4 no individualized activities for her. *The resident had liked listening to Neil Diamond and loved to watch the Twins games on TV. *She revealed those activities should have been provided to the resident. *She stated the provider had no policy in place for residents who were bedbound or unable to participate in group activities. Interview on 4/23/14 at 9:30 a.m. with the director of nursing (DON) regarding resident 1 revealed she agreed: *The resident should have been provided with activities and being in her room alone with no stimulation to her senses would be a hardship on her mental well-being. *Activities needed to be on the care plan, so staff would know what to provide. *The care plan had not been updated to reflect activities. Interview with the administrator on 4/23/14 at 3:50 p.m. regarding resident 1 revealed he agreed this resident or any other who had been bedbound would require individualized activities to promote mental health.	F 248			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 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.	F 280	F280 Right to Participate Planning Care 1. There is no corrective action to be taken for the care plan of resident 1 as she passed away on 4/26/14. The care plans of all dependent residents were audited to ensure information regarding fluid needs, repositioning and activity care planning (please also see F248) is available to staff.	6/13/14	

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F 280	<p>Continued From page 5</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to have an updated revised care plan for one of one resident (1) with a significant change who was bedbound. Findings include:</p> <p>1. Observations at random times on 4/22/14 and 4/23/14 of resident 1 in her room revealed: *She was lying in bed on her back. *She had cried and repeatedly asked for water from this surveyor. *She had been unable to reach her water glass or press her call light in her weakened state. *She complained of pain with movement.</p> <p>Interview on 4/22/14 at 2:30 p.m. with certified nursing assistant (CNA) G regarding resident 1 revealed: *She had been bedbound for a week.</p>	F 280	<p>2. All residents have to potential to be effected by this practice.</p> <p>3. Nursing staff will be educated by Director of Nursing by 6/11/14 regarding when, by whom, and how to make changes to care plans. Nursing staff was also educated by 6/11/14 regarding what constitutes a change in a residents condition.</p> <p>4. MDS Coordinator or designee will randomly audit 5 resident care plans to ensure that the care plan is updated with residents current status. Audits will be completed weekly for 4 weeks, then monthly for 3 months or until all resident care plans have been audited. Results of these audits will be presented to the monthly QAPI committee by the DNS or designee for review and recommendation.</p>	

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F 280	<p>Continued From page 6</p> <p>*Staff would offer her sips of water only every two hours when they repositioned her and only after the resident would ask for cold water.</p> <p>*Staff would go into the room approximately every two hours to reposition her in bed.</p> <p>Review of the current care plan for resident 1 revealed there was no information available for staff on:</p> <p>*How often or how much the resident would need for fluids to maintain hydration.</p> <p>*How often the resident would need to be repositioned.</p> <p>*Activities to provide for her mental well-being since her significant change.</p> <p>Interview with the director of nursing (DON) on 4/23/14 at 9:30 a.m. regarding resident 1 revealed she agreed:</p> <p>*The care plan had not been individualized or revised for the resident since her significant change that had occurred one week before this survey.</p> <p>*Staff needed accurate information on the level of care the resident needed that was detailed and specific.</p> <p>*The resident would need repositioning more than approximately every two hours to prevent pressure ulcers.</p> <p>*Sips of water every two hours had not been enough to maintain hydration for the resident.</p> <p>*There had been no activities for the resident since her significant change one week ago.</p> <p>Observation and interview on 4/23/14 from 10:45 a.m. to 11:00 a.m. with licensed practical nurse (LPN) A revealed:</p> <p>*She did not make changes to the care plan, the Minimum Data Set (MDS) coordinator did that.</p>	F 280			

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F 280	Continued From page 7 *When asked how the MDS coordinator would know about the significant change in resident 1's care she stated, "That's a good question, I don't know." *She agreed there was no communication between floor staff and the MDS coordinator to revise and update resident 1's care plan, and it had not been done. Review of the provider's May 2011 Care Plan policy stated care plans were to be reviewed and revised if there was a change in a resident's condition.	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: 32355 Based on observation, interview, record review, and policy and guideline review, the provider failed to ensure: *Professional standards were followed for one randomly reviewed medication card matching the physician's order and medication administration record (MAR) for one of nine sampled residents (17). *A seat belt alarm had been assessed and documented on for appropriate use for one of one sampled resident (11). Findings include: 1. Review of resident 17's March 2014 MAR revealed lorazepam (anti-anxiety medication) 0.5	F 281	F281 Services Provided Meet Professional Standards 1. Resident #17's lorazepam order was corrected on 4/24/14. Resident #11's seatbelt was assessed and care planned on 5/6/14. LPN A was educated on 5/14/14 regarding proper procedure for medication administration and disposal. The medication card and the medication administration record for all residents will be checked by 6/11/14. 2. All residents have to potential to be effected by this practice. 3. Nursing staff responsible for medication administration will be educated by 6/11/14 regarding appropriate administration and disposal of medication. Nursing staff and interdisciplinary care plan team responsible for updating care plans will be educated by 6/11/14 regarding assessment and care planning according to resident needs.	6/13/14

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F 281	<p>Continued From page 8 milligram (mg) every a.m.</p> <p>Observation on 4/23/14 at 8:05 a.m. of licensed practical nurse (LPN) A revealed: *She had prepared to administer resident 17 his medications. *She had placed several of his medications in a small plastic cup. One of those medications had been the lorazepam. *The pharmacy label on the lorazepam card had read "Lorazepam 1.0 mg every 8 hours as needed." *She had placed one of the lorazepam pills in the medication cup along with his other medications.</p> <p>Interview during the above observation with LPN A revealed: *She had not observed the discrepancy between the MAR and the pharmacy label on the medication card. *She would have administered the medication to the resident had this surveyor not questioned the discrepancy. *She reviewed the current physician's orders at that time. Resident 17 was to have been given the 0.5 mg dose of lorazepam. *She could not recall how long they had been administering resident 17 the wrong dose of medication. *She had retrieved the lorazepam from all the medications in the plastic cup with her fingers. No gloves had been utilized. *She had placed that pill back in the medication card and gave the card containing the lorazepam to the director of nursing (DON) to follow-up with the medical doctor. *She proceeded to administer the rest of the medications in the plastic cup that she had touched with her fingers.</p>	F 281	<p>4. DNS or designee will randomly audit 2 staff persons responsible for medication administration to ensure that medications are administered and disposed of appropriately. Audits will be completed weekly for 4 weeks, then monthly for 3 months or until all staff persons responsible for medication administration have been audited. MDS coordinator or designee will audit 5 resident medical records to ensure that the assessments and care plan reflect residents current needs. Audits will be completed weekly for 4 weeks then monthly for 3 months or until all resident medical records have been audited. These audits will be presented by the DNS or designee to the monthly QAA committee for review and recommendation.</p>	

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F 281	<p>Continued From page 9</p> <p>Interview on 4/23/14 at 3:23 p.m. with LPN A revealed she: *Should have compared the medication label to the MAR. *Should have used gloves or a spoon to retrieve the lorazepam from the rest of the medications in the plastic cup. *Should not have replaced the pill back in the medication card. It should have been destroyed according to the provider's policy. *Should not have given the DON the lorazepam card. The medication card should have been replaced in the medication cart until she had been able to assist the DON with the discrepancy.</p> <p>Interview on 4/24/14 at 8:15 a.m. with the DON on the above observations further confirmed the interview with LPN A. She had not been aware resident 17 had been receiving the wrong dose of lorazepam. She was unsure how long he had been receiving the wrong dose. It had been the nurses responsibility to ensure all residents received the right medication.</p> <p>Review of the provider's October 2007 Medication Administration General Guidelines policy revealed: **"Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule." **"Read medication label three times before preparing/pouring medication." **"Once removed from the package/container,</p>	F 281		

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F 281	<p>Continued From page 10</p> <p>unused medication doses shall be disposed of according to the nursing care center policy."</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 6th Edition, St. Louis Mo., 2005, page 841, revealed "When administering medications, the nurse compares the label of the medication container with the medication form."</p> <p>2. Random observations from 4/22/14 through 4/24/14 of resident 11 revealed when she was sitting in her wheelchair (w/c) she had been wearing a seatbelt wrapped around her waist.</p> <p>Interview and observation on 4/23/14 at 3:25 p.m. with resident 11 revealed: *She was not sure why she had been wearing a seatbelt when sitting in her w/c. *She had been able to unhook the seatbelt upon request from this surveyor. *The seatbelt had made a loud beeping sound when unhooked.</p> <p>Review of resident 11's entire medical record revealed no documentation, assessment, or care planning in place to explain the reasoning for the seatbelt alarm.</p> <p>Interview on 4/23/14 at 4:30 p.m. with the Minimum Data Set (MDS) coordinator revealed: *She had not been aware resident 11 had been wearing a seatbelt alarm. *She had stated resident 11 had a history of falls, and a seatbelt alarm would have been used for that reason. *The seatbelt alarm would alert the staff when she had attempted to get out of her w/c. *The seatbelt alarm should have been</p>	F 281			

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F 281	Continued From page 11 documented on in the nurses progress notes and written on her care plan. *The nurses had been responsible for the updating of the care plans at the nurses station with any current changes. She would have checked those care plans and entered any changes into the computer. Interview on 4/24/14 at 8:20 a.m. with the DON regarding resident 11 revealed: *She had not been aware the resident had been wearing a seatbelt alarm. *She was unsure when the seatbelt alarm had been applied to the resident's w/c. *She and the MDS coordinator could not locate any documentation to support the use of the seatbelt alarm. *She would have expected to find documentation, assessments, and care planning in place to support the use of the seatbelt alarm for the resident. Review of the provider's revised 2013 Restraint Evaluation and Utilization guidelines 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."	F 281			
F 309 SS=G	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.	F 309	F309 Provide Care/Services for Highest Well Being 1. MD was contacted on 4/23/14 and orders for pain management were obtained for resident 1. CNA G was educated on 5/15/14 regarding symptoms of pain and reporting symptoms of pain to a nurse. LPN A was educated on 5/14/14 regarding pain assessment and pre-medicating a resident as needed prior to completion of a dressing change and her responsibility to report medication changes to oncoming nursing staff at the end of her shift. All residents will be audited for pain by 6/11/14.	6/13/14	

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F 309	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and guideline review, the provider failed to administer pain medication as ordered for one of one resident (1) who was bedbound and had severe joint pain. Findings include:</p> <p>1. Observation on 4/22/14 at 2:25 p.m. of resident 1 in her room revealed: *She was lying in bed on her back. *She complained of severe pain with movement.</p> <p>Interview on 4/22/14 at 2:30 p.m. with certified nursing assistant (CNA) G regarding resident 1 revealed: *She had been bedbound for a week. *Staff would go into the room approximately every two hours to reposition the resident in bed. *When staff repositioned her it would cause her pain, and she would cry out.</p> <p>Observation on 4/22/14 at 4:40 p.m. of resident 1 in her room revealed CNA G had repositioned her in bed, causing her to cry out in pain.</p> <p>Observation and interview on 4/23/14 at 8:05 a.m. with resident 1 revealed: *She was lying in bed on her back. *She complained of pain and had tears in her eyes. *When asked if the nurses had given her medication for pain she replied, "Sometimes, not always. It hurts when they move me. They get kind of rough and it makes me cry."</p>	F 309	<p>2. All residents have to potential to be effected by this practice.</p> <p>3. Direct care staff will be educated by 5/20/14 regarding pain assessment; use of the pain rating scale; pain medication administration; and follow up documentation of effectiveness of pain medications and processing physician orders timely and shift to shift communication.</p> <p>4. DNS or designee will audit 5 resident to staff interactions during repositioning and or dressing change to ensure the residents pain is managed appropriately. DNS or designee will audit 5 resident medical record for administration of pain medication, use of the pain rating scale and follow up documentation of effectiveness of pain medications audits will be completed weekly for 4 weeks, then monthly for 3 months. DNS or designee will audit nurse to nurse end of shift report weekly for 4 weeks then monthly for 3 months, audits will include each shift one time per week/month. DNS or designee will audit 5 resident medical records to ensure that physicians orders were processed in a timely manner. Results of these audits will be presented by the DNS or designee to the monthly QAPI committee for review and recommendation.</p>	

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F 309	<p>Continued From page 13</p> <p>Observation and interview on 4/23/14 from 10:45 a.m. to 10:50 a.m. with licensed practical nurse (LPN) A performing a dressing change on resident 1's left leg revealed:</p> <ul style="list-style-type: none"> *The resident cried in pain with movement of her leg. *She did offer to stop the dressing change, but the resident said "No, just get it over with." *She had not pre-medicated the resident with available as needed pain medication prior to her dressing change. *She stated she usually gave the resident her pain medication two hours prior to a dressing change at around 8:00 a.m. daily. *Her dressing change was at approximately 10:00 a.m. daily. *She had not assessed her for pain. <p>Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> *Hydrocodone (a pain medication) 5/325 milligrams (mg) 1 to 2 tablets by mouth as needed for pain in joint or generalized pain. *Hydrocodone had been given only once in April, 2014 at 6:44 a.m. on 4/20/14 prior to the times reported to this surveyor for dressing changes for resident 1. <p>Interview on 4/23/14 at 3:00 p.m. with LPN A revealed she had just received an order from the physician. Morphine and Ativan (a pain reliever and an anti-anxiety medication) were ordered for pain control for resident 1.</p> <p>Observation and interview on 4/24/14 at 10:15 a.m. with resident 1 in her room revealed:</p> <ul style="list-style-type: none"> *She could be heard from the hallway crying out in pain for help. *She reported to this surveyor she "hurt so bad." *Staff had recently repositioned her. 	F 309		

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F 309	Continued From page 14 Interview on 4/24/14 at 10:25 a.m. with LPN F and the director of nursing (DON) regarding resident 1 revealed: *She had received hydrocodone from LPN F at approximately 7:00 or 7:30 a.m. that morning. *She was unaware of the new physician's order for pain medication received by LPN A the previous day. *LPN A had not reported to nursing staff the Morphine and Ativan order had been received. *The DON had remembered LPN A telling this surveyor about new pain medication the previous day and found the order. *The DON stated they would get Morphine from the provider's emergency medicine box and have nursing staff administer it right away to the resident for pain control. *The DON also agreed LPN A had not reported the new medication to oncoming nursing staff at the end of her shift. *The DON agreed there had been a system failure that needed to be corrected right away. Review of the provider's revised January 2011 Pain management Guideline revealed: *Its purpose was a guideline for nursing staff for consistent assessments, management and documentation of pain in order to provide maximum comfort and enhanced quality of life. *The nurse would update the plan of care to reflect changes in pain medication and evaluate the resident for its effectiveness.	F 309			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration	F 327	F327 Sufficient Fluid to Maintain Hydration 1. There is no corrective action to be taken for resident I as this resident passed away on 4/26/14.	6/13/14	

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F 327	<p>Continued From page 15 and health.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and record review, the provider failed to ensure sufficient fluid intake for one of one resident (1) who was bedbound with a known recent history of dehydration. Findings include:</p> <p>1. Observation on 4/22/14 at 2:25 p.m. of resident 1 in her room revealed: *She was lying on her back in bed in her room. *She had dry cracked lips. *She had cried and repeatedly asked for water from this surveyor. *She had been unable to reach her water glass or press her call light in her weakened state.</p> <p>Interview on 4/22/14 at 2:30 p.m. with certified nursing assistant (CNA) G regarding resident 1 revealed: *She had been bedbound for a week. *Staff would offer her sips of water every two hours when they repositioned her and only after the resident would ask for cold water.</p> <p>Interview on 4/22/14 at 3:10 p.m. with licensed practical nurse (LPN) A regarding resident 1 revealed: *She had been bedbound for approximately one week. *Her physician had been to the facility the previous day (4/21/14) and spoke with her about hospice care and end of life care. *They were waiting for the approval from family to begin hospice care.</p>	F 327	<p>2. All residents have to potential to be effected by this practice.</p> <p>3. Nursing staff will be educated by 6/11/14 regarding the importance of hydration and offering fluids to dependent residents.</p> <p>4. DNS or designee will audit residents for symptoms of dehydration, and resident to staff interaction to ensure that staff are offering fluids to dependent residents. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the DNS or designee to the monthly QAPI committee for review and recommendation.</p>		

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F 327	Continued From page 16 Observation on 4/22/14 at 4:30 p.m. and at 6:00 p.m. revealed: *She had cried and repeatedly asked for water again to this surveyor. *She complained of pain to this surveyor. Review of the medical record for resident 1 revealed: *She had a recent history of dehydration in February 2014. *A 4/20/14 nurses note stated "Stayed in bed, continued to bleed out rectum, large amount mixed with BM (bowel movement). Family and Dr. (doctor) notified." *Weight loss total in the last three months had been 28 pounds, an 18.1% weight loss. Interview with the director of nursing (DON) on 4/23/14 at 9:30 a.m. regarding resident 1 revealed she agreed: *The resident was at high risk for further dehydration given her recent history. *Water needed to be offered and provided by staff more frequently than every two hours. *Sips of water were not sufficient for the resident to remain hydrated. *Dehydration would increase the resident's pain. There were no fluid intake records nor a policy provided to this surveyor. Per the DON: "No records are kept on any resident except those with a fluid restriction or urinary catheters (tube inserted into the bladder)."	F 327			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441	F441 Infection Control	6/13/14	

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F 441	<p>Continued From page 17</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which 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: 32355</p>	F 441	<p>1. LPN A was educated on 5/14/14 regarding hand hygiene, glove use, universal precautions, and handling of soiled items. LPN B was educated on 5/13/14 regarding the proper procedure for cleaning of nebulizer masks. Housekeeping manager and housekeeping aide C were educated on 5/14/14 regarding standard isolation procedures, including the proper chemicals to be used for the environment of a resident with a diagnosis of Carbapenem Resistant Enterobacteriaceae. The nebulizer devices for resident 18 and 19 were replaced on 4/23/14. Expired medications and laboratory specimen equipment removed from medication room and destroyed according to facility policy on 4/24/14. DNS completed an audit of the medication room on 4/24/14 to ensure that there were no more expired medications or laboratory specimen equipment present.</p> <p>2. All residents have to potential to be effected by this practice.</p> <p>3. Staff will be educated by 6/11/14 regarding hand hygiene, glove use, universal precautions, and handling of soiled items and standard isolation procedures. An informative binder listing residents on isolation precautions, and isolation protocols associated with resident #5 was placed at the nurses station on 5/14/14. Staff will be made aware of this binder by 6/11/14. Housekeeping staff will be educated by 6/11/14 regarding their responsibly to consult with a nurse regarding the reasons for a resident to be on isolation. Housekeeping staff will be educated by 6/11/14 regarding the proper chemical to be used in a residents environment according to the reason for isolation. Staff responsible for medication administration will be educated by 6/11/14 regarding the proper procedure for cleaning of nebulizer masks and facility policy on expired medication and laboratory supplies.</p>	

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F 441	<p>Continued From page 18</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained:</p> <p>*For one of one observed resident (18) with bodily secretions dripping from the tip of his nose.</p> <p>*To ensure the proper chemicals were being used by the housekeeping department for one of one sampled resident (5) placed in isolation (remains in room) with a diagnosis of Carbapenem Resistant Enterobacteriaceae (CRE) (bacterial infection).</p> <p>*To ensure two of two residents (18 and 19) nebulizer treatment apparatus had been cleansed and put away in a sanitary manner by two of two observed nurses (A and B).</p> <p>*To ensure one of one medication room did not contain expired medications and laboratory specimen equipment.</p> <p>Findings include:</p> <p>1. Observation on 4/22/14 at 5:10 p.m. of licensed practical nurse (LPN) A while assisting resident 18 with a draining wound from the tip of his nose revealed:</p> <p>*He had been sitting in a wheelchair (w/c) in his room. He had a scabbed area on the tip of his nose that was draining a moderate amount of blood.</p> <p>*The blood had dripped down the front of his shirt, pants, on his face, and was on both of his hands.</p> <p>*LPN A put on a pair of gloves and with those gloves she:</p> <ul style="list-style-type: none"> -Retrieved a hand towel out of his bathroom. -Touched the handle on the faucet, turned on the water, and wet the towel. -Used the wet towel to wipe the blood off of his face, nose, hands, shirt, and pants. -Replaced the blood stained towel back on the 	F 441	<p>4. DNS or designee will audit 5 staff to resident interactions to ensure that care and services are provided in a sanitary manner. DNS or designee will randomly audit 2 staff persons responsible for medication administration to ensure that they use correct standard precautions and practice proper medication administration (please also see F281). DNS or designee will audit the medication room to ensure that there are no expired medications or laboratory specimen equipment present. DNS or designee will randomly audit staff who enter the room of a resident on isolation precautions to ensure the correct use of personal protective equipment. DNS or designee will audit 2 staff persons responsible for administration of a nebulizer treatment to ensure that the nebulizer device is cleansed in a sanitary manner. Executive Director or designee will audit the cleaning of isolation rooms to ensure that housekeeping staff are using the correct chemicals to clean the resident environment. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the DNS or designee and the Executive Director or designee to the monthly QAA committee for review and recommendation.</p>		

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F 441	<p>Continued From page 19</p> <p>towel rack in resident 18's bathroom.</p> <p>-Repositioned his legs on the footrest attached to the w/c.</p> <p>-Grabbed the handles on his w/c and pushed him out to the nurses' station.</p> <p>*She had removed her gloves and did not wash or sanitize her hands.</p> <p>*She had opened the treatment cart and retrieved a Band-Aid.</p> <p>*She put on another pair of gloves and had placed the Band-Aid on resident 18's nose.</p> <p>*She removed her gloves and washed her hands.</p> <p>Interview on 4/23/14 at 3:05 p.m. with LPN A regarding the observation confirmed she had not ensured a sanitary process was maintained.</p> <p>Interview on 4/24/14 at 8:20 a.m. with the director of nursing (DON) revealed:</p> <p>*She was the infection control nurse for the facility.</p> <p>*She confirmed the above process had not been a sanitary process.</p> <p>*LPN A should have placed the soiled towel in a plastic bag for laundry to wash.</p> <p>*LPN A should have removed her gloves and washed her hands prior to adjusting his legs and moving him out to the nurses' station.</p> <p>*There had been potential for cross-contamination to occur.</p> <p>Review of the provider's August 2012 Medical Waste Handling policy revealed:</p> <p>***"Medical waste will be handled and disposed of safely and in accordance with regulatory requirements."</p> <p>***"Disposable items soiled with blood or other potentially infectious materials must be placed in plastic bags or containers, and a solution of one</p>	F 441		

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F 441	<p>Continued From page 20</p> <p>(1) part bleach registered germicidal and nine (9) parts water added to saturate the items.</p> <p>2. Observation on 4/22/13 at 11:45 a.m. of resident 5's room revealed: *There had been a bedside dresser outside of the room. Inside of the dresser were gloves, disposable yellow gowns, and red biohazardous garbage bags. *A sign had been posted on the entrance door to the room to visit with the nurse prior to entering the room.</p> <p>Interview on 4/22/13 with housekeeping aide C at the time of the above observation revealed: *He had been aware resident 5 was in isolation (unable to come out of the room). *He was to have worn a gown, gloves, and a mask while cleaning that room. *He had been unaware as to why resident 5 had been placed in isolation. *He had not known if the chemicals he was using to clean resident 5's room were effective for that type of isolation. He would have had to ask his supervisor.</p> <p>Interview on 4/22/13 at 11:50 a.m. with the housekeeping supervisor revealed: *She had been working in the facility since October 2013. *She had been aware resident 5 was placed in isolation and had been in isolation prior to her employment at the facility. *She had no knowledge as to why resident 5 had been placed in isolation. *She stated she had never been informed by the nursing staff as to why resident 5 was in isolation. *She had been unaware if the chemicals the housekeeping department was using to disinfect</p>	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014	
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH		STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451		
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F 441	<p>Continued From page 21</p> <p>his room was effective.</p> <p>*She had not been aware if their department should have been using any special type of chemicals to disinfect this room. She would have had to ask her supervisor.</p> <p>*As the supervisor it had been her responsibility to ensure the housekeeping department had been using the correct chemicals to disinfect resident 5's room.</p> <p>*She agreed there should have been a process in place to ensure the correct cleaning products were being used.</p> <p>Interview on 4/23/14 at 11:25 a.m. with the administrator revealed:</p> <p>*The housekeeping department had been contracted by another company to work in their facility.</p> <p>*The provider had a meeting every morning to discuss any special issues and precautions in the facility.</p> <p>*Special issues and precautions would have been discussed prior to any new admissions.</p> <p>*The housekeeping supervisor had attended those meetings. She was responsible for ensuring her staff had been responsible for any education regarding appropriate chemicals to be used in the facility.</p> <p>*The housekeeping supervisor was responsible for ensuring the appropriate chemicals had been utilized for any special precautions/issues in the facility.</p> <p>Review of the provider's August 2012 Isolation - Initiating Transmission - Based Precautions revealed all staff were to have seen the nurse prior to entering a room with a sign posted on the door indicating special precautions were required.</p>	F 441		

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F 441	<p>Continued From page 22</p> <p>3a. Observation on 4/22/14 at 4:15 p.m. of LPN A with resident 19 revealed:</p> <ul style="list-style-type: none"> *She had assisted the resident with a nebulizer treatment (medication for the lungs administered through a mask). *She had removed the mask from the resident's face upon completion of the nebulizer treatment. *She had rinsed the mask and chamber that held the medication for administration with tap water. *While rinsing the medication chamber she had dropped it on the floor. *She had picked the chamber up off the floor and rinsed it again under tap water. *She returned the chamber and mask back to the resident's bedside table for storage and re-use. <p>Interview on 4/23/14 at 3:08 p.m. with LPN A regarding the above observation confirmed she should have thrown the nebulizer administration equipment away and retrieved a new one.</p> <p>Interview on 4/24/14 at 8:10 a.m. with the DON regarding the above observation further confirmed LPN A should have thrown the nebulizer administration equipment away and retrieved a new one.</p> <p>b. Observation on 4/23/14 at 10:15 a.m. with LPN B revealed:</p> <ul style="list-style-type: none"> *She had assisted resident 18 with a nebulizer treatment. *After cleansing the medication chamber and mask with tap water she had retrieved two paper hand towels. *With those paper hand towels she had: <ul style="list-style-type: none"> -Turned off the tap water. -Returned the mask and medication chamber to the resident's bedside table for storage. -Laid the medication chamber and mask directly 	F 441		

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F 441	<p>Continued From page 23 on top of the paper towels she had used to turn off the tap water.</p> <p>Interview on 4/23/14 at the time of the observation with LPN B confirmed she should have thrown those paper towels away and retrieved clean ones.</p> <p>Review of the provider's October 2007 Medication Administration policy for Nebulizer's revealed they were to have been cleaned per the manufacturer's instructions and stored in the medication carts.</p> <p>4. Observation on 4/24/14 from 8:30 a.m. through 8:50 a.m. of the medication room revealed: *Two Novolog (medication to control sugar levels in the blood) insulin flexpens. Those Novolog insulin flexpens had expiration dates of 1/13/14 and 11/14/13. *The following expired laboratory specimen equipment: -Multiple laboratory test tubes for blood draws with expiration dates of March 2014 and February 2014. -Four q-tip culture swabs for determining bacterial growth had an expiration date of May 2013.</p> <p>Interview on 4/23/14 at the time of the above observation with the DON revealed all the nursing staff had been responsible for checking the medication room for expired medications and laboratory specimen equipment. She had been unaware of all the above expired items.</p> <p>Review of the provider's October 2007 Medication Administration General Guidelines policy revealed the expiration date was to have been checked on packages and containers. The policy had not</p>	F 441		

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F 441	Continued From page 24 stated how often or who was responsible for checking the expiration dates on the packages and containers.	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/22/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/22/14. Golden LivingCenter-Ipswich 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	<p><i>Addendums noted with an asterisk per 6/13/14 telephone to facility administrator. JB/DDDH/MF</i></p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
K 038 SS=C	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, interview, and record review, the provider failed to install a paved path of exit discharge to the public way at two of four exits (north wing and west wing). Findings include: 1. Observation at 10:15 a.m. on 4/22/14 revealed the exit from the north wing had a landing that ended approximately 55 feet from the nearest street. The exit from the west wing also had a landing that ended approximately 150 feet from	K 038	<p>K038</p> <ol style="list-style-type: none"> Maintenance Supervisor educated on 5/19/14 regarding the need for exits to be readily accessible at all times. A contractor has been scheduled to install sidewalks by 6/13/14. All residents have to potential to be effected by this practice Maintenance Supervisor will schedule a contractor to install sidewalks by 6/13/14 Maintenance Supervisor will conduct a one time audit to insure all exits are readily available to a paved sidewalk by 6/13/14. Findings will be reported to the monthly QAPI committee for review and recommendation. 	6/13/14

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

Tom Seaton

TITLE: Executive Director * 04/22/14 JB/DDDH/MF

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 disseminated 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 disseminated 30 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.

JUN 02 2014
Facility ID: 0038
SD DOH L&C

MAY 20 2014
Continuation sheet Page 1 of 2
SD DOH L&C

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 038	Continued From page 1 the parking lot. Interview with the administrator and maintenance supervisor at the time of the observations confirmed those conditions. Review of the previous life safety code survey dated 1/29/13 confirmed that finding.	K 038			

ORIGINAL

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10635	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOMENDAAL DRIVE IPSWICH, SD 57451
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S 000	Initial Comments Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/22/14 through 4/24/14. Golden LivingCenter - Ipswich was found not in compliance with the following requirements: S206 and S210.	S 000	<p><i>Addendums noted with an asterisk per 6/13/14 telephone to facility administrator. DK/SDDOH/IMF</i></p> <p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p> <p>S206 Personnel Training</p> <ol style="list-style-type: none"> Staff will be educated by 6/11/14 regarding dining assistance, nutritional risks and hydration needs of the residents. All residents have the potential to be effected by this practice. Dietary Services Manager and DNS were educated on 5/19/14 regarding on going education requirements as outlined in S206. Education regarding dining assistance, nutritional risks and hydration needs of the residents will be added to the annual training calendar. DNS or designee will perform a one time audit to ensure that dining assistance, nutritional risks and hydration needs of the residents has been added to the annual training calendar. Results of this audit will be presented to the QAPI committee for review and recommendation. 	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks , and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206		

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

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Continuation sheet 1 of 4

SOUTH DAKOTA DEPARTMENT OF HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10635	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/24/2014
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S 206	Continued From Page 1 This Rule is not met as evidenced by: Surveyor: 12218 Based on record review and interview, the provider failed to ensure the annual required in-service training sessions for dining assistance, nutritional risks, and hydration needs of the residents had been offered to all the staff. Findings include: 1. Review of the annual required in-service agendas for 2013 revealed: *Dining assistance, nutritional risks, and hydration of residents had not been presented. *Dining assistance included observation and awareness of resident eating requirements, assistance with encouragement, substitutions to be offered, feeding precautions to prevent choking and swallowing difficulties, types of fluids to use to prevent choking, changes in eating abilities and time requirements, necessity of encouraging residents to feed themselves or assist in feeding, social atmosphere of the dining room, room trays, and reheating of foods. *Nutritional risks usually included dangers of weight loss and weight gain, risks of nutrient deficiency, awareness of diet requirements such as dysphagia (difficulty in swallowing), diabetic, protein, lactose (allergy to dairy products), gluten (allergy to foods containing oats, wheat, barley and rye grains), fluid restrictions, nutrient requirements, poor eating habits, and importance of meal/food consumption records, and awareness of the residents at nutritional risk. *Hydration included prevention of dehydration, fluid requirements, foods high in liquids, ways to get the resident to drink more fluids, signs and symptoms of dehydration, medications causing loss of fluids or constipation, and environmental influences. Interview on 4/24/14 at 9:15 a.m. with the	S 206		

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S 206	Continued From Page 2 certified dietary manager and at 10:10 a.m. with the director of nursing confirmed: *The in-service had not been included in their annual required staff in-services. *They were unaware of the above requirement for nutrition and dining assistance. *They had a list of in-services outlined that had been given, but it did not include the above requirement.	S 206		
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Rule is not met as evidenced by: Surveyor: 33488 Based on record review and interview, the provider failed to ensure health assessments (free from communicable diseases) for five newly hired employees (H, I, J, K, and L) were done. Findings include:	S 210	S210 Employee Health Program 1. Health assessments will be completed for employees H, I, J, K and L by 6/11/14. An audit of all employee records will be completed by 6/11/14 to ensure that employee health assessments are complete. 2. All residents have the potential to be effected by this practice. 3. DNS was educated on 5/19/14 regarding the need for a health assessment to be completed for all employees hired. 4. Business Office Manager (BOM) will perform audits of employee records to ensure that a health assessment is completed. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the BOM to the monthly QAPI committee for review and recommendation.	6/13/14

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S 210	Continued From Page 3 1. Record review of the above newly hired employees revealed there was no documentation a health assessment had been done to ensure they were free from communicable disease prior to employment or within fourteen days after employment but before assignment of duties. Interview with the administrator on 4/24/14 at 4:00 p.m. revealed he was unaware that was a state requirement for all employees. The provider had no policy in place to ensure the requirement had been met.	S 210		