

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

ORIGINAL

PRINTED: 02/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445	
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F 000	INITIAL COMMENTS Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/27/15 through 1/28/15. Golden LivingCenter - Groton was found not in compliance with the following requirements: F281, F323, and F371.	F 000	<i>Addendums noted with an asterisk per 3/10/15 telephone to facility DON JAKDDOH/ME</i> 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 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: 32331 Based on interview, record review, and policy review, the provider failed to ensure professional standards were followed for: *Completion of neurological (brain function) checks for one of one sampled resident (2) with documentation of a head injury. *Clarification of physician's orders for a medication for one of nine sampled residents (5). Findings include: 1. Review of resident 2's medical record revealed: *She had been admitted on 8/23/12. *She had a history of falls. *She had an unwitnessed fall on 6/29/14 at 7:55 p.m. in her room. *She had been found laying on her right side between the foot of her bed and the TV stand. *Registered nurse (RN) B had been on duty at the time of the fall and had filled out a Change in	F 281	F281 Services Provided Meet Professional Standards 1. Staff nurse #B was not re-educated due to her separation from Golden Living Centers prior to survey completion. All other nursing staff will be educated on 2/24/15 on un-witnessed falls in residents with cognitive impairment and neurological/vital sign follow-up. All residents have potential to be effected. Resident #5's physician was contacted on 1/27/15 with request for clarification of order for medicated cream in question. Physician clarified and signed said order. All nursing staff will be educated on policy and procedure regarding clarification of orders on 2/24/15. All residents have potential to be effected. 2. The Interdisciplinary Team will review falls every weekday during morning stand-up meeting, to ensure that proper follow up has been completed All nursing staff will be educated on policy and procedure regarding clarification of orders on 2/24/15. 3. Audits will be performed by the Director of Nursing or her designee to ensure appropriate neurological/vital sign follow-up of falls for 12 weeks.	*3/19/15 JAKDDOH/ME

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

TITLE

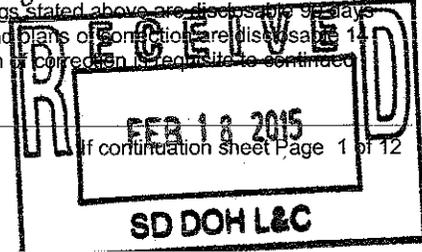
(X6) DATE

Michelle Ann AVMS

Dir of Nrg

2/17/15

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 180 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 281	<p>Continued From page 1 Condition Report.</p> <p>Review of the 6/29/14 Change in Condition report filled out by RN B revealed: **Pt [patient] is confused and has had falls in the past." **"...not oriented to place or time." **Pt pleasantly confused, usual self." **Hematoma [a collection of blood outside of a blood vessel] to right forehead, large bruise to right shoulder blade, small skin tear on right elbow, 2 larger skin tears above right elbow." *The resident refused to have been seen in the emergency room (ER). *Family had been called and had not wanted her to go the ER. *Physician had been notified.</p> <p>Review on the 6/30/14 Post Fall Analysis/Plan for resident 2 revealed: *Vitals taken at the time of the fall had included: -Blood pressure: 173/85 millimeters of mercury (mm/Hg)(normal range is 90/60 mm/Hg to 120/80 mm/Hg). *She had impaired safety awareness and judgment. *No neurological (neuro) checks (assessment of mental status) had been documented following the fall. *That above assessment of mental status would have included: -Date and time of assessment. -Eye opening. -Verbal response. -Motor response. -Pupillary (of or affecting the eye pupils) response. -Limb response. -Vital signs (a measurement of the body's basic</p>	F 281	<p>Audits will be performed by the Director of Nursing or her designee on physician orders on 5 charts/week for 4 weeks; 5 charts/week for 8 weeks, to ensure any questioned orders have been clarified with physician.</p> <p>4. Results of these audits will be presented by the Director of Nursing to the monthly QAPI committee for review and recommendation. Substantial compliance will be in place by March 19, 2015.</p>		

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F 281	<p>Continued From page 2</p> <p>functions including body temperature, blood pressure, pulse, and respiratory or breathing rate).</p> <p>Interview and record review on 1/28/15 at 11:15 a.m. with the director of nursing regarding resident 2's fall on 6/29/14 revealed:</p> <p>*The resident had not had any neuro checks after the fall.</p> <p>*She would have expected neuro checks after a fall with a head injury.</p> <p>*She stated neuro checks should have been done on a Neurological Assessment form.</p> <p>*There had not been a thorough assessment at the time of the fall to have included neuro checks.</p> <p>*She was not aware nurses had not performed neuro checks or continued to assess and monitor the resident after she had an unwitnessed fall.</p> <p>Review of the provider's 12/18/14 Neurological Checks policy revealed:</p> <p>*Neurological checks on residents were to have been completed as clinically appropriate, which had included a head injury.</p> <p>*Neurological checks would have been performed per physician order.</p> <p>- "Conduct neurological checks as follows: -Every 15 minutes for the first hour; -Every 30 minutes X 4; -Every 60 minutes times 2; then -Every shift for 72 hours." -There was no physician order for neurological checks.</p> <p>*Neurological assessment and documentation on the flow sheet should have included: -Date and time of assessment. -Eye opening. -Verbal response. -Motor response.</p>	F 281		

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F 281	<p>Continued From page 3</p> <p>-Pupillary response. -Limb response. -Vital signs.</p> <p>Review of the provider's 1/22/15 Falls Management Guideline revealed: *Following a resident's fall the licensed nurse was to have assessed the resident for injuries. *That assessment had included neuro checks if indicated.</p> <p>Review of the provider's 11/13/14 Falls Change of Condition Guidelines for Completion revealed the licensed nurse should have documented ongoing assessments which had included neurological documentation per the provider's policy.</p> <p>Surveyor: 23059 2. Review of resident 5's January medication administration record (MAR) revealed there was an entry for clotrimazole-betamethasone cream (for redness and itching) to have been applied topically (to the skin) on her hands at bedtime on odd days. That cream was started on January 15, 2015.</p> <p>Review of that same MAR revealed an entry for betamethasone-dipropionate cream (for redness and itching) to have been applied to her hands at bedtime every two days. That entry had been discontinued on January 14, 2015.</p> <p>Review of resident 5's January 2015 physician's orders signed on 1/6/15 revealed an order for betamethasone-dipropionate cream to have been applied to the hands at bedtime every two days. No order was found on the chart to discontinue that cream and start the</p>	F 281			

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F 281	Continued From page 4 clotrimazole-betamethasone. Interview on 1/27/15 at 2:45 p.m. with licensed practical nurse (LPN) A revealed the pharmacist had changed the order back to the clotrimazole-betamethasone. That order had been on resident 5's original 12/22/14 admission orders. LPN A confirmed at that time no one had clarified the order with the physician to ensure specifically what cream he had intended to use for the resident. Interview on 1/28/15 at 1:35 p.m. with the director of nursing (DON) revealed the nurses should have clarified the order with the physician. She confirmed no order was found to discontinue the dipropionate and restart the clotrimazole.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT 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: 32331	F 323	F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 1. Grab bar/safety assessment was completed for Resident #5 on 2/3/15 and resident #9 on 2/2/15 to assess appropriate use of grab bars. Assessment revealed that grab bars/side rails were appropriate for resident #5. Assessment revealed that grab bars/side rails were not necessary for resident #9. Grab bars were removed from resident #9's bed on 2/3/15. Staff will be educated re: need for initial and quarterly	*3/19/15 JA/SDDH/ME

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F 323	<p>Continued From page 5 Surveyor: 32572 A. Based on observation, record review, interview, and policy review, the provider failed to ensure safety assessments had been completed prior to resident use of grab bars for two of five sampled residents (5 and 9) with grab bars. Findings include:</p> <p>1. Observation on 1/28/15 at 12:30 p.m. of resident 9's bed revealed he had grab bars at the top third head of his bed on both sides.</p> <p>Review of his medical record revealed: *He had been admitted on 12/23/14. *His diagnoses were: -Alzheimer's disease (decline in thought processes). -Dementia (decline in thought processes). -Psychosis (mental illness). -Anxiety. -Depression. -Nervousness. -Wandering. -Hypertension (high blood pressure). *There had been no safety assessment for the use of grab bars. *The care plan indicated: -He wandered at night. -He had been at risk for falls. -No mention grab bars were to have been used. *His most current 12/30/14 Minimum Data Set assessment (MDS) indicated a cognitive (thought processes) testing score to be 0. That indicated severe cognitive impairment.</p> <p>Interview on 1/28/15 at 2:20 p.m. with the director of nursing (DON) regarding resident 9 confirmed he did have grab bars on his bed. There had been no safety assessment completed prior to</p>	F 323	<p>grab bar assessments for all residents who staff are considering use of grab bars on 2/24/15. All residents have potential to be effected.</p> <p>2. Staff will be educated regarding need for initial and quarterly grab bar assessments for all residents who staff are considering use of grab bars on 2/24/15.</p> <p>3. Audits will be performed by the Director of Nursing or her designee on 5 charts/week for 4 weeks, 5 charts/week for 8 weeks to ensure assessment process is completed.</p> <p>4. Results of these audits will be presented by the Director of Nursing to the monthly QAPI committee for review and recommendation. Substantial compliance will be in place by March 19, 2015.</p>	

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F 323	<p>Continued From page 6</p> <p>application of those bars. He had a severe decline in his thought process and did not have safety awareness. The DON confirmed the provider did not have a policy on safety assessments for grab bars, but did have a policy for side rails. The provider also did have a Side Rail Assessment Screen which reviewed the safety.</p> <p>Surveyor: 23059 2. Observation on 1/27/15 at 9:12 a.m. revealed there were grab bars on both sides of resident 5's bed.</p> <p>Review of the resident's 12/22/14 side rail assessment revealed she was able to turn from side to side unassisted. That assessment stated side rails would not be utilized at that time. No further assessment was found in her medical record.</p> <p>Interview on 1/27/15 at 10:55 a.m. with resident 5 revealed she used the grab bars routinely to assist with turning in bed. She stated she had used something similar on her bed at home.</p> <p>Interview on 1/28/15 at 1:30 p.m. with the DON confirmed the completed assessment stated the resident would not use side rails. She stated a reassessment should have been done at the time the grab bars were added to resident 5's bed.</p> <p>Review of the provider's revised 2013 Side Rails Guideline policy revealed: *"The purpose of the Side Rail Utilization may be to: -Remind resident not to get out of bed when medically contraindicated and/or medical equipment is attached to the patient.</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>-Aid in turning and repositioning while in be. -Providing a hand-hold for getting in or out of bed. *Assessment and Documentation: -Assessment is completed to identify potential benefits from utilizing side rails and minimize risks. -If side rails are being considered assessment will be completed at that time with ongoing reassessment (at least quarterly). -Care plan interventions are implemented when side rails are utilized and reviewed at least quarterly."</p> <p>B. Based on observation and interview, the provider failed to ensure four of four used sharps (a device used to puncture the skin) containers were secured and unaccessible to residents in one of one observed soiled utility room. Findings include:</p> <p>1. Observation beginning on 1/27/15 at 8:00 a.m. and continuing through 1/28/15 at 12:30 p.m. in the soiled utility room on the 200 hall revealed: *The door to the room was unlocked. *There were four full discarded sharps containers on the counter.</p> <p>Interview at that time with the maintenance supervisor revealed they were unsure as to why those sharps containers were in an unlocked room. They stated those containers previously had been locked in the medication room while awaiting disposal.</p> <p>Interview on 1/28/15 at 1:30 p.m. with the DON revealed those sharps containers used to have been locked in the medication room. She stated when the facility received a larger medication distribution system the soiled utility room became</p>	F 323	<p>F323 FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>1-B. The four full sharps containers were removed from the soiled utility room on 1/28/15. New nursing staff were educated on the proper storage of full sharps containers in a secure location on 1/29/15.</p> <p>2-B. Nursing staff will keep full sharps containers in the locked med room awaiting Biohazard disposal. They will notify maintenance of the need to remove the sharps containers from the med room for disposal.</p> <p>3-B. Audits will be completed by the Director of Nursing or her designee on a weekly basis x 4, then monthly x2.; to ensure the proper storage and disposal of full sharps containers.</p> <p>4-B. Results of these audits will be presented by the Director of Nursing to the monthly QAPI committee for review and recommendation. Substantial compliance will be in place by March 19, 2015.</p>		

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F 323	Continued From page 8 the "default area" to store them. She confirmed those containers should have been kept locked up and away from the potential of residents getting to them. The provider did not have a policy regarding the security of the sharps containers awaiting disposal. Review of the provider's undated Accident Prevention policy revealed the safety committee would inspect all areas of the building at least twice yearly. The committee would look at unsafe work practices.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for the following in the kitchen: *Ten of ten shelving units in the dry food storeroom had uncleanable surfaces. *One of one cooler threshold had a one-half inch wide crevice (an opening) in the floor filled with debris.	F 371	F371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1. Shelving units will be replaced by stainless steel wire shelving. Walk-in cooler threshold crevice will be filled and sealed. Walk-in cooler walls and ceiling were cleaned of grease and dust 1/27/15. All residents have potential to be effected. 2. Shelving units will be replaced by stainless steel wire shelving. Walk-in cooler threshold crevice will be filled and sealed. Education to the Dietary Manager regarding the policy on walk-in cooler cleaning schedule on 2/16/15. 2/19/15 MURH 3. Once the stainless steel wire shelves are in place, the Dietary Manager will ensure a cleanable surface monthly for 12 weeks. Once the walk-in cooler threshold is repaired, Dietary Manager will ensure a cleanable surface monthly for 12 weeks. The Dietary Manager will audit the cooler cleaning schedule and walls and ceiling to ensure cleaned and documented for 12 weeks.	* 3/19/15 JAP/SDDH/ME	

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F 371	<p>Continued From page 9</p> <p>*One of one walk-in cooler's walls and ceiling had a moderate accumulation of grease with dust on it. Findings include:</p> <p>1. Observation on 1/27/15 in the kitchen from 7:35 a.m. through 7:53 a.m. revealed: *Ten painted shelving units in the dry food storeroom contained resident food and supplies that had a moderate amount of chipped and peeling paint on them. -Those shelving units were no longer cleanable surfaces. *One of one walk-in cooler threshold had a one-half inch wide crevice in the floor filled with debris. -That cooler threshold was no longer a cleanable surface. *One of one walk-in cooler had a moderate accumulation of dust on randomly located areas on all the walls and the ceiling. -The above cooler was used for storage of residents' food.</p> <p>Interview on 1/27/15 at 3:40 p.m. with the administrator and the maintenance supervisor regarding the above areas in the kitchen revealed they agreed: *The shelving units in the dry food storeroom had a moderate amount of chipped and peeling paint and needed to have been replaced. *The walk-in cooler threshold had a crevice in the floor that was filled with debris, and it needed to be cleaned out and filled in.</p> <p>Interview on 1/28/15 at 7:30 a.m. with the dietary manager regarding the above areas in the kitchen revealed she agreed: *The shelving units in the dry food storeroom had</p>	F 371	<p>4. Results of these audits will be presented by the Dietary Manager to the monthly QAPI committee for review and recommendation. Substantial compliance will be in place by March 19, 2015.</p>		

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F 371	<p>Continued From page 10</p> <p>a moderate amount of chipped and peeling paint and needed to have been replaced.</p> <p>*The walk-in cooler threshold had a crevice in the floor that was filled with debris and that it needed to be a cleanable surface.</p> <p>*The walk-in cooler was on a monthly cleaning schedule.</p> <p>-That cooler had last been cleaned in November 2014.</p> <p>-It needed to have been cleaned each month or more often if needed.</p> <p>Review of the kitchen cleaning schedules for 2014 through January 27, 2015 revealed:</p> <p>*The walk-in cooler shelves were to have been wiped down monthly.</p> <p>-Those shelves had last been cleaned in November 2014.</p> <p>*None of the other areas in the walk-in cooler were on the cleaning schedule including the:</p> <p>-Ceiling.</p> <p>-Walls.</p> <p>Review of the provider's 2011 Floor Safety policy revealed the floors were to have been kept clean, free of grease, and build-up.</p> <p>Review of the provider's 2011 Storing Dry Food policy revealed the shelving should have been clean and free of chipped or peeling paint.</p> <p>Review of the provider's 2011 Cleaning Walk-in Refrigerators and Freezers policy revealed:</p> <p>*The walk-in refrigerator was to have been cleaned monthly with the following steps:</p> <p>-Remove food items and shelving from the unit.</p> <p>-Store food items in another refrigerator during cleaning.</p> <p>-Remove the shelves, then wash and sanitize</p>	F 371			

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

PRINTED: 02/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/28/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445		
(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 371	Continued From page 11 using a brush if necessary. -Wash the inside thoroughly with warm water and detergent. -Rinse with a sanitizing solution following manufacturer's directions for the proper strength. -Cool unit to proper temperature and replace the food items. Review of the provider's 2011 Storage of Refrigerated Foods revealed food was to have been properly stored according to guidelines.	F 371			

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

ORIGINAL

PRINTED: 02/09/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435048	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2015
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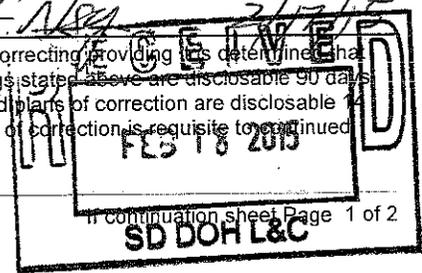
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/28/15. Golden LivingCenter - Groton was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiency identified at K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per a 67115 telephone to facility social services director. <i>CH/KDDH/ME</i></p>	
K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure one of five exits (north exit) was readily accessible at all times. Findings include:</p> <p>1. Observation beginning at 9:45 a.m. on 1/28/15 revealed the exterior door at the north exit was equipped with a magnetic lock. The sign at the door location indicated the lock was a delayed egress style operating mechanism. Testing of the door by pushing on the crossbar revealed the</p>	K 038	<p>K038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <ol style="list-style-type: none"> On 1/29/15 United Technologies adjusted magnetic lock for proper operation. All residents have potential to be affected. On 1/29/15 United Technologies adjusted magnetic lock for proper operation. Maintenance Director or his designee will audit all egress doors on a weekly basis 12 weeks. Results of these audits will be presented by the Maintenance Director to the monthly QAPI committee and Safety Committee for review and recommendation. Substantial compliance will be in place by March 19, 2015. 	<p>* 3/19/15 <i>CH/KDDH/ME</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Michelle Penovans</i>	TITLE <i>Dir of Nsg</i> (X6) DATE <i>2/7/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing its determination 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 7 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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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON			STREET ADDRESS, CITY, STATE, ZIP CODE 1106 NORTH SECOND STREET GROTON, SD 57445		
(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 magnetic lock would not activate the release process. Further testing by the maintenance supervisor revealed the lock would release if tried several times. It was noted the magnet and plate on the door and frame pivoted with the testing of the door. Interview with the maintenance supervisor at the time of the testing revealed the service provider was to be in the building that day, and he would have the device checked that day.	K 038			

ORIGINAL

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/28/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 N 2ND ST GROTON, SD 57445
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S 000	<p>Initial Comments</p> <p>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 1/27/15 through 1/28/15. Golden LivingCenter - Groton was found not in compliance with the following requirements: S166 and S301.</p>	S 000	<p><i>Addendums noted with an asterisk per 2/19/15 telephone to facility per JALSDDH/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>	
S 166	<p>44:04:02:17(1-10) OCCUPANT PROTECTION</p> <p>The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;</p>	S 166	<p>S166 OCCUPANT PROTECTION</p> <ol style="list-style-type: none"> On 1/29/15 United Technologies installed an audible alarm at the nurses station. All residents have potential to be affected. On 1/29/15 United Technologies installed an audible alarm at the nurses station. Maintenance Director or his designee will audit all egress doors on a weekly basis 12 weeks. Results of these audits will be presented by the Maintenance Director to the monthly QAPI committee and Safety Committee for review and recommendation. Substantial compliance will be in place by March 19, 2015. 	<p><i>* 3/19/15 JALSDDH/MF</i></p>

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

Michelle Demmons

TITLE

Sur.

(X6) DATE

STATE FORM

6899

206J11

RECEIVED

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If continuation sheet 1 of 5

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/28/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 N 2ND ST GROTON, SD 57445
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S 166	<p>Continued From page 1</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition. The exit door at the service entrance (west exit) had a push button bypass. Findings include:</p> <p>1. Observation and testing beginning at 9:30 a.m. on 1/28/15 revealed the exterior door at the service entrance/exit had a red push button mounted on the door frame on both the interior and exterior of the door. The interior door of the vestibule for the exit had a delayed egress magnetic lock installed.</p> <p>Testing of the delayed egress magnetic lock revealed it alarmed at the door location but was not audible to the surveyor. Interview with the maintenance supervisor at the time of the observation revealed the alarm did not sound at the nurses station. He stated that alarm was on</p>	S 166		

South Dakota Department of Health

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S 166	Continued From page 2 the exterior door of the vestibule. Testing of the exterior door revealed the alarm did sound at the nurses station. Testing of the red push button (labeled 'push to exit') and then opening the exterior door revealed the alarm was silenced. Further interview with the maintenance supervisor revealed the push button was in place to allow staff and deliveries to enter the vestibule without setting off the alarm. A keypad was installed in the vestibule to allow staff to release the magnetic lock and enter the building. Interview with the maintenance supervisor at the time of the observations confirmed those findings.	S 166		
S 301	44:04:07:16 Required dietary inservice training The dietary manager or the dietitian in ...nursing facilities... shall provide ongoing inservice training for all dietary and food-handling employees... Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure six of nine required annual in-service training sessions (food safety, food handling and preparation techniques,	S 301	S301 REQUIRED DIETARY INSERVICE TRAINING 1. Dietary Consultant will provide directed in-service to all staff that handle food; to include: food safety, hand washing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. 2. All current and newly hired staff that will be handling food will receive the above training upon hire and on an annual basis. 3. The Director of Nursing or her designee will complete an annual audit of the in-service roster to ensure that all food-handling staff have received the required training. 4. Results of these audits will be presented by the Director of Nursing to the monthly QAPI committee for review and recommendation. Substantial compliance will be in place by March 19, 2015.	*3/19/15 JAK/DOH/ME

South Dakota Department of Health

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S 301	<p>Continued From page 3</p> <p>food-borne illness, serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service) were offered for all food-handling staff yearly. Findings include:</p> <p>1. Record review of the required in-service training sessions from November 2013 through January 2014 for all food handling staff revealed: *Those staff had received no annual training on the following: -Food safety. -Food handling and preparation techniques. -Food-borne illness. -Serving and distribution procedures. -Leftover food handling policies. -Time and temperature controls for food preparation and service.</p> <p>Interview on 1/28/15 at 8:30 a.m. with the dietary manager and at 10:20 a.m. with the director of nursing regarding required annual in-service training sessions for all food handlers revealed: *Food handling staff were identified as dietary, nursing, and activities. *There had not been an in-service on food safety, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service for nursing and activities staff. *They had not known that all food handling staff were to have received that annual in-service training.</p> <p>Interview on 1/28/15 at 2:20 p.m. with the administrator and the director of nursing revealed they confirmed the required annual in-serving training sessions for all food handlers had not</p>	S 301		

South Dakota Department of Health

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S 301	Continued From page 4 occurred. Review of the provider's 2011 In-Service Education policy revealed an ongoing education program would have been planned and implemented for the development and improvement of skills.	S 301		