

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

ORIGINAL

PRINTED: 11/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2015
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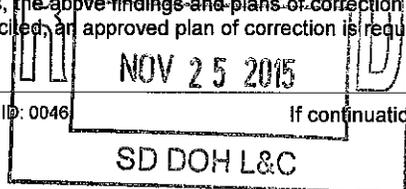
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LAKE NORDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 803 PARK STREET POST OFFICE BOX 139 LAKE NORDEN, SD 57248
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F 000	INITIAL COMMENTS Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/2/15 through 11/4/15. Golden LivingCenter -Lake Norden was found not in compliance with the following requirements: F280, F281, F309, and F371.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 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. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy	F 280	Resident 3's Care Plan was revised on 11/4/2015 and states resident is a Full Code to match the code status on the Advanced Directive. The code status has been removed from the nurse report. A member of the care team completed an initial audit of all residents to verify their care plan code status matches the Advanced Directive on 11/15/2015. All residents have the potential to be affected by this practice. The care team reviewed and signed the Advance Directive Review. This policy states the Care Plan must match the Advanced Directive.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Theresa DeBijer</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>11/23/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 280	<p>Continued From page 1</p> <p>review, the provider failed to accurately revise the care plan regarding advance directives (written instructions for health care decisions if a resident was unable to act or respond for themselves) for one of one sampled resident (3). Findings include:</p> <p>1. Review of resident 3's complete medical record revealed: *She had been admitted on 9/6/13. *On 10/8/15 her physician had signed a Resuscitation (revive) Orders form for: -"In the event of a cardiac [heart] and/or respiratory [lungs and breathing], initiate CPR [Cardiopulmonary Resuscitation]." *CPR means that if she had suffered a cardiac or respiratory arrest (the heart suddenly stops beating or breathing stops) efforts were to have been made to resuscitate (revive) her.</p> <p>Review of resident 3's revised 8/3/15 care plan revealed: *She had an advance directive for a full code (all life-saving measures were to have been done). *That had been changed to DNR (do not resuscitate) on 9/2/14. *CPR to have been performed as ordered had been discontinued on 9/2/14. *Her wishes were to have been honored as written on the care plan.</p> <p>Interview on 11/3/15 at 9:40 a.m. with registered nurse (RN) A and on 11/4/15 at 8:40 a.m. with RN D regarding resident 3's advance directives revealed: *They would have both checked the provider's Twenty-four Hour Report Nurse Communication form. -That form contained documentation she was a</p>	F 280	<p>The Care Team will update the care plan code status when there are any changes and with a new admit. A member of the care team will audit 5 random residents a week for 4 weeks and then monthly for a total of 1 year to ensure the code status in the care plan matches the Advanced Directive. A member of the care team will bring the results of these audits to the monthly QAPI Meetings for further review and recommendations.</p>	12/21/2015

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F 280	Continued From page 2 DNR. Interview on 11/3/15 at 9:00 a.m. with the director of nursing regarding resident 3 and her advance directives revealed: *She confirmed the resident had a physician's order for CPR to have been initiated. *The current care plan had not matched the physician's order. *The care plan had not been accurately revised and updated. *The charge nurse upon each resident's admission and the care team after admission were responsible for updating and revising the care plan as needed.	F 280			
F 281 SS=D	Review of the provider's 2/26/15 Interdisciplinary Care Plan policy revealed the interdisciplinary care plan was to have been revised/updated as necessary to address resident needs. 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: 33265 Based on observation, interview, record review, and guidelines review, the provider failed to: *Verify the correct dosage of a medication (med) prior to administration during 1 of 33 random resident (8) medication administration observations during 1 of 33 medication passes by 1 of 2 (RN A) nurses. *Ensure the physician's order for continuing	F 281	Resident #8 Prevacid medication order was clarified with physician and corrected as soon as error was identified. Resident #8 order for Hospice was added to the electronic medical record and printed out on the monthly summary sheet of physician orders. Residents residing in the facility who take medications and have Hospice orders have the potential to be affected in a		

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F 281	<p>Continued From page 3</p> <p>hospice care was added to the monthly summary sheet of physician's orders for 1 of 2 residents (8) on hospice care. Findings include:</p> <p>1. Observation and record review on 11/3/15 at 10:15 a.m. with registered nurse (RN) A during a medication administration to resident 8 revealed: *The medication administration record (MAR) in the electronic medical record said to give thirty milligrams (mg) of Prevacid (stomach med) daily. *The label on the plastic bag containing the medication said to give one tablet every day. The tablets were labeled as fifteen mg. *RN A gave resident 8 fifteen mg of Prevacid.</p> <p>Interview with RN A on 11/3/15 at 2:00 p.m. regarding the above medication administration revealed: *She had not noticed the difference in milligrams between the MAR and the label on the medication container. *She had been administering only one fifteen mg tablet.</p> <p>Further interview with RN A on 11/3/15 at 4:00 p.m. revealed: *She found the hospice orders dated 9/18/15 were for only fifteen mg of Prevacid daily instead of the thirty mg the physician had previously ordered and she notified hospice. *Hospice had contacted the physician on 11/3/15 at 3:20 p.m. *On 11/3/15 at 3:27 p.m. the physician ordered the resident was to be on thirty mg of Prevacid given daily.</p> <p>Interview with the director of nursing on 11/4/15 at 11:20 a.m. revealed:</p>	F 281	<p>similar manner. Residents have had their medication orders reviewed and verified with medications being administered. Residents on Hospice have had orders validated in the electronic medical record to ensure they are printed out on the monthly summary sheet of physician orders.</p> <p>Licensed nurses and medication aides will be re-educated on the medication administration policy and adding Hospice orders to the electronic medical record to ensure they are printed out on the monthly summary sheet of physician orders.</p> <p>Director of Nursing or designee will complete a random audit of 5 residents weekly for 4 weeks then monthly for 3 months to ensure physician orders and medications administered are accurate. And an audit to review all residents on hospice current Hospice orders are entered in the electronic medical record to ensure they are printed out on the monthly summary sheet of physician orders weekly for 4 weeks and monthly for 3 months.</p>	

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F 281	<p>Continued From page 4</p> <p>*She had not been made aware of the medication error described above.</p> <p>*She agreed it was a medication error.</p> <p>Review of the provider's May 2012 Medication Administration-Preparation and General Guidelines revealed there were four medication checks to have been done before giving a medication:</p> <p>*First check should have been with the medication container label and the MAR.</p> <p>*Second check should have been done after the medication was removed from the container and checked with the MAR again.</p> <p>*Third check was to have been after the medication was prepared to administer and was to verify the medication label with the MAR again.</p> <p>*Final check of the medication dosage on the label and in the MAR was to have happened prior to administration.</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, p. 583, revealed the steps to take to prevent medication errors included to read labels at least three times, comparing the medication administration record (MAR) and the label before administering the medication.</p> <p>2. Review of resident 8's complete medical record revealed:</p> <p>*He had been placed on hospice care on 9/18/15.</p> <p>*The physician's 10/13/15 summary order sheet had not included an order to continue hospice care.</p> <p>Interview with the DON on 11/4/15 at 11:20 a.m. revealed she agreed the physician's order to continue hospice care was not included on the</p>	F 281	<p>Director of Nursing will bring results of audits to the monthly QAPI meetings for further review and recommendations.</p>	12/21/2015	

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F 281	Continued From page 5 most recent physician's order summary form. Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., St. Louis, Mo, 2013, p. 305, revealed the nurse was responsible for transcribing physician's orders correctly.	F 281	*Addendums noted with an asterisk per 12/15/15 per email with facility administrator. NPN/SDDOH/EC	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and hospice contract review, revealed the provider failed to have a combined care plan for hospice and the facility for 2 of 12 sampled residents (5 and 8). Findings include: 1. Observation and interview on 11/2/15 at 4:30 p.m. with registered nurse (RN) A regarding resident 5 revealed he: *Had a diagnosis of paranoid schizophrenia (fearful or suspicious mental illness losing touch with reality). *Would remain in his room unless he was participating in smoking breaks. *Would often refuse care. *Was placed on hospice care on 9/9/15.	F 309	*The policy states the frequency of hospice visits will be listed in the care plan. Hospice will also complete a checklist during Resident 8's Care plan was reviewed and updated on 11/18/2015. The Care plan for resident 8 was integrated with the hospice care plan on 11/18/2015. No updates to resident 5 as resident is deceased. All residents currently receiving hospice will have their care plans reviewed and integrated with hospice by 12/21/2015. All residents receiving hospice services have the potential to be affected by this practice The care team created a Hospice Care Plan policy. All members of the Care team have reviewed this policy. All residents admitting to hospice will have care plans integrated with hospice. A member of the care team will audit all residents receiving hospice monthly for 12 months to ensure the hospice is integrated into the care plan. A member	*What cares they will provide on their next visit. NPN/SDDOH/EC *and that checklist for cares is being completed. NPN/SDDOH/EC

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F 309	<p>Continued From page 6</p> <p>Review of the current undated care plan for resident 5 revealed no mention of what the facility or hospice's responsibilities were in caring for the resident.</p> <p>Interview on 11/3/15 at 4:00 p.m. with RN A revealed: *When asked how anyone would know what care to provide for resident 5 she replied "I just know." *She agreed there was no clear delegation of responsibilities of what care hospice provided and what care the provider was responsible for.</p> <p>Interview on 11/3/15 at 4:15 p.m. with the director of nursing (DON) revealed she agreed there was no clear responsibility of care assigned between hospice or the provider.</p> <p>Surveyor: 33265 2. Review of resident 8's complete medical record revealed: *He was placed on hospice on 9/18/15. *The facility care plan dated 7/14/15 had "admitted to hospice 9/18/15" handwritten under each focus area. *No specific information regarding when hospice personnel were coming, which hospice personnel were coming, or what hospice personnel would be doing for the resident. *The hospice care plan dated 9/18/15 stated: -Ongoing updates would be communicated by hospice to the long term care facility. -The long term care facility would integrate the changes into their care planning system.</p> <p>3. Interview with the DON on 11/4/15 at 11:20 a.m. regarding the above revealed: *She agreed the two care plans were not</p>	F 309	<p>of the care team will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.</p>	12/21/2015

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F 309	Continued From page 7 integrated. *They had no policy or procedure on care plans. Surveyor 33488 Review of the 9/11/15 contracted hospice program's plan of care revealed no assigned duties that would direct who was to provide the care given to resident 5 and 8 between hospice or the provider. Review of the 9/17/13 contract between hospice and the provider revealed: *Hospice was to have assigned an RN to coordinate care. **"The plan of care shall be developed in full consultation of both Hospice and the Facility. The parties agree each shall maintain its portion of the Plan of Care in accordance with laws and regulations..."	F 309			
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	F 371	The tiles that are not cleanable next to the steam table will be replaced . The floor in the kitchen's refrigerator and storage room will be painted by the Maintenance director. There will be no clean dishes or utensils on the second or third shelves of the meal carts leaving the kitchen . Their will be a cloth covering all clean dishes and utensils of the top shelf. All residents have the potential to be affected by these practices.		

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F 371	<p>Continued From page 8</p> <p>sanitary conditions were maintained for the following:</p> <p>*Two of two broken floor tiles in the kitchen next to the steam table and food production table with a moderate accumulation of black and brown spots and grease.</p> <p>*One of two floors in the kitchen (refrigeration and storage area) had a moderate accumulation of chipped and peeling paint.</p> <p>*The dishes and silverware being transported from the central kitchen to the memory care unit dining room were uncovered for two of two observed meals for all residents served there. Findings include:</p> <p>1. Observation on 11/2/15 in the kitchen from 1:05 p.m. through 1:25 p.m. revealed:</p> <p>*An accumulation of black and brown spots and grease on two of two broken tiles located next to an electrical outlet box in the floor.</p> <p>-The above tiles had an exposed area of approximately six inches long and one-half to one inches deep on two sides of each of the tiles.</p> <p>-Those tiles were located next to the steam table and food preparation table that contained resident food.</p> <p>*The floor in the kitchen's refrigerator and storage area had a moderate accumulation of chipped and peeling paint exposing the cement.</p> <p>Interview on 11/3/15 at 8:20 a.m. with the maintenance director regarding the above broken tiles and flooring revealed:</p> <p>*He agreed the tiles were broken and no longer were cleanable.</p> <p>*He agreed the floor had a moderate amount of peeling and chipped paint with multiple areas of exposed cement.</p> <p>-That flooring was no longer a cleanable surface.</p>	F 371	<p>The Maintenance Director was educated on the Maintaining Dietary Equipment policy.</p> <p>The dietary staff to be educated on the kitchen sanitation policy.</p> <p>The maintenance director or designee will audit the paint on the kitchen floor and the tiles in the kitchen to ensure they are cleanable surfaces monthly for 3 months and then quarterly with the environmental rounds.</p> <p>The dietary manager or designee will randomly audit 2 meal services a week for 4 weeks and 2 meals a month for 3 months to ensure clean items are covered properly and no clean utensils or dishes are on the second and third shelf.</p> <p>The Dietary Manager and Maintenance Director or designee will bring the results of these audits to the monthly QAPI Meetings for further review and recommendations.</p>	12/21/2015	

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F 371	<p>Continued From page 9</p> <p>*He stated he was responsible for the tiles and the flooring in the kitchen. *He stated he checked those areas at least monthly.</p> <p>Interview on 11/4/15 at 8:45 a.m. with the dietary manager (DM) regarding the above broken tiles and flooring revealed she agreed: *The tiles were broken and no longer cleanable. *The floor had a moderate amount of peeling and chipped paint with multiple areas of exposed cement. -That floor was no longer a cleanable area. *Dietary was responsible for sweeping and mopping the floors daily. *Housekeeping was responsible for floor care quarterly. *Maintenance was responsible for any floor repair.</p> <p>Interview on 11/4/15 at 9:45 a.m. with the administrator regarding the above broken tiles and flooring revealed she agreed: *The tiles were broken and no longer cleanable. -Those tiles had been broken for at least two years. *The floor had a moderate amount of peeling and chipped paint with multiple areas of exposed cement. -That floor was no longer a cleanable area.</p> <p>Review of the provider's November 2015 Preventative Maintenance Schedule revealed: *Daily interior (inside the building) rounds and inspections were to have been completed. *There was no specific task listed for the tiles and floor in the kitchen on that schedule.</p> <p>Review of the provider's 2011 Floor Safety policy</p>	F 371			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 10</p> <p>revealed the floors were to have been clean, free of grease and chemical build-up, and dry at all times.</p> <p>Review of the provider's 2011 Cleaning Kitchen Areas policy revealed the following guidelines for quarterly maintenance of floors: *Check floors for chipped and/or peeling paint. *Keep in good repair.</p> <p>2. Observation on 11/2/15 at 5:05 p.m. with certified nursing assistant G revealed: *She had left the kitchen with a three-tiered cart with a tablecloth over the top. *That cart had contained: -Dishes on the second shelf and silverware on the third shelf that had been left uncovered. *She took the above cart down a service hallway, through a dining room, and a resident hallway to the memory care unit dining room.</p> <p>Observation and interview on 11/2/15 at 5:45 p.m. with dietary assistant (DA) F revealed: *She returned the same above cart from the memory care unit dining room back to the kitchen. *That cart's second shelf contained: -Twenty-five uncovered bowls turned upright. -Four uncovered small plates. -Six plastic glasses turned on their sides and two spoons in an opened container. *That cart's third shelf contained one dozen knives in an opened container. *She stated the dishes and silverware on the second and third shelf were considered clean as they had not been used by the residents. *She stated the same cart containing those items would be used at the next meal for the memory care unit dining room.</p>	F 371			

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/04/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LAKE NORDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 803 PARK STREET POST OFFICE BOX 139 LAKE NORDEN, SD 57248		
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F 371	<p>Continued From page 11</p> <p>Observation on 11/3/15 at 11:30 a.m. with both cook E and DA F revealed: *Cook E left the kitchen with a steam table that had contained six uncovered plates on the second shelf. *DA F left the kitchen with the same cart as the above with a tablecloth over the top. -That cart had contained: -Multiple uncovered bowls, plates, glasses, and silverware. *Cook E took the above steam table and DA F took the above cart down a service hallway, through a dining room, and a resident hallway to the memory care unit dining room. *DA F placed the cart next to an unoccupied resident couch in the memory care unit dining room during meal service.</p> <p>Interview on 11/3/15 at 11:50 a.m. with the director of the memory care unit revealed she agreed: *The above dishes and silverware had not been covered when transported from the kitchen to the memory care unit. *Those items needed to have been covered during transport due to the possibility of contamination. *The cart that contained uncovered and cleaned dishes should not have been placed next to a resident couch.</p> <p>Interview on 11/4/15 at 8:45 a.m. with the DM regarding the above revealed she agreed: *The above dishes and silverware had not being covered when transported from the kitchen to the memory care unit. *Those items needed to have been covered during transport due to the possibility of</p>	F 371			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/04/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LAKE NORDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 803 PARK STREET POST OFFICE BOX 139 LAKE NORDEN, SD 57248		
(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	<p>Continued From page 12 contamination.</p> <p>Interview on 11/4/15 at 9:45 a.m. with the administrator revealed she agreed: *The above dishes and silverware had not being covered when transported from the kitchen to the memory care unit. *Those items needed to have been covered during transport due to the possibility of contamination.</p> <p>Review of the provider's 2011 Food Service Distribution policy revealed the dining room service silverware should have been covered, so it had not been exposed.</p> <p>Review of the provider's 2011 Handling Clean Equipment and Utensils revealed: *Store clean and sanitized portable (moveable) equipment and utensils so that food contact surfaces were protected from splash, dust, and other contaminants. *Tableware should have been protected from contamination by being covered. *All tableware would have been removed, washed, and sanitized between seatings even if not used.</p>	F 371			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2015
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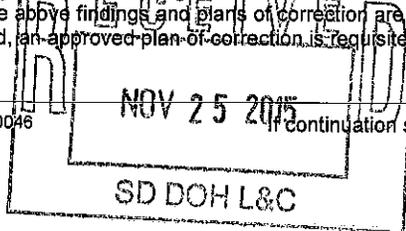
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LAKE NORDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 803 PARK STREET POST OFFICE BOX 139 LAKE NORDEN, SD 57248
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/03/15. Golden LivingCenter-Lake Norden was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **11/23/15**

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 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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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LAKE NORDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 803 PARK ST POST OFFICE BOX 139 LAKE NORDEN, SD 57248
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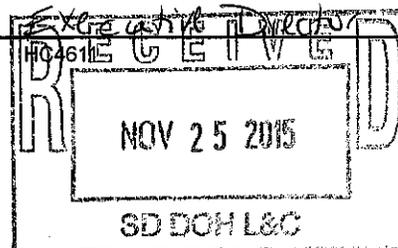
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 11/2/15 through 11/4/15. Golden LivingCenter-Lake Norden was found not in compliance with the following requirements: S236 and S294.	S 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;	S 236	No correction can be taken at this time for employee B and C since they are already late. Employees hired at Golden Living Center Lake Norden have the potential to be affected in a similar manner GLC - Lake Norden will adhere to the SD State Guidelines related to TB screenings. Employees will receive directions when they receive their first TB test for when they need to return for checks and the second test. An audit of employee files will be completed to ensure compliance to the State regulation Director of Nursing Services or designee will complete a weekly audit for 4 weeks then monthly for 3 months on all new employees to ensure compliance. Director of Nursing will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.	12/21/2015

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

TITLE

(X6) DATE

Theresa DeB...



11/23/15

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10639	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - LAKE NORDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 803 PARK ST POST OFFICE BOX 139 LAKE NORDEN, SD 57248
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S 236	<p>Continued From page 1</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure two of five sampled employees (B and C) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of employment. Findings include:</p> <ol style="list-style-type: none"> 1. Review of staff member B's complete employment record revealed: *The date of hire was 8/27/15. *The TB skin test had been completed twenty-two days after being hired. 2. Review of staff member C's complete employment record revealed: *The date of hire was 8/20/15. *The TB skin test had been completed fifteen days after being hired. 3. Interview on 11/3/15 at 3:00 p.m. with the business manager revealed: *The date of employment was the same date as the date of hire for the above employees. *She had not known why those above employees had not been given their TB skin tests in a timely manner. *The nursing staff was responsible for the employees TB skin tests to have been given in a timely manner. <p>Interview on 11/4/15 at 8:25 a.m. with the administrator regarding the TB screenings for employees B and C revealed: *She agreed the TB skin tests had not been given within fourteen days of employment.</p>	S 236		

South Dakota Department of Health

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S 236	Continued From page 2 *Those TB skin tests had not followed the state guidelines for TB screenings for new employees. Review of the provider's 8/14/15 Tuberculosis, Screening Employees, and New Hires policy revealed each newly hired employee would have been screened for TB infection and disease after an employment offer had been made but prior to the employee's duty assignment.	S 236		
S 294	44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, shall be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or qualified dietitian. Each planned menu shall be approved, signed, and dated by the dietitian for each facility. Any menu changes from month to month shall be reviewed by the dietitian and each menu shall be reviewed and approved by the dietitian at least annually if applicable. Each menu as served shall meet the nutritional needs of the residents in accordance with the physician's, physician assistant's, or nurse practitioner's orders and the Dietary Guidelines for Americans, 2010. A record of each menu as served shall be filed and retained for 30 days. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on interview and policy review, the provider failed to ensure the menu changes for all residents on oral diets were reviewed and approved from month-to-month by the consultant registered dietitian (RD). Findings include:	S 294	All menu changes will be discussed with the RD by phone or email and will obtain signature on the RDs next visit. All Menu changes will be noted at the bottom of the menu and approved by the RD before implementation . All residents have the potential to be affected by this practice. The Dietary Services manager and all cooks will be educated on the Menu Changes and Planning policies. The Dietary Services Manager or designee will audit the menus weekly for 4 weeks and then monthly for 3 months to ensure no changes have been made to the menus without RD approval. The Dietary Manager or designee will bring the results of these audits to the monthly QAPI Meetings for further review and recommendations.	12/21/2015

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

GOLDEN LIVINGCENTER - LAKE NORDEN

**803 PARK ST POST OFFICE BOX 139
LAKE NORDEN, SD 57248**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 294	<p>Continued From page 3</p> <p>1. Group interview with seven random residents on 11/2/15 at 9:30 a.m. revealed the menu had not always matched what was posted to have been served for the residents.</p> <p>Interview on 11/3/15 at 11:20 a.m. with cook E revealed there was at least one menu change per week with a total of at least five menu changes per month.</p> <p>Interview on 11/4/15 at 8:45 a.m. with the dietary manager (DM) revealed the following: *There had been changes on the menu for the residents. *There was no documentation of menu substitutions approved by the RD. *The menu was reviewed and approved by the RD every three months prior to the menu being posted. -Changes or substitutions from those above menus after they had been posted were not being approved by the RD. *Menu changes were to have been documented, reviewed, approved, and signed by the RD. *The provider was not following their policy for menu substitutions.</p> <p>Review of the provider's 2011 Menu Changes policy revealed: *A change or substitution in the menu and the reason were to have been recorded on the bottom of the menu. *All menu changes required the RD's review, approval, and signature. *The DM was to have notified the RD by phone to discuss and obtain verbal approval for the menu substitution. *The DM was to have recorded the phone approval with date and time on the menu. *The RD was to have reviewed and signed the</p>	S 294		

South Dakota Department of Health

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S 294	Continued From page 4 menu change on the menu during the next onsite visit.	S 294		