

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/17/15 through 8/20/15. Golden LivingCenter - Madison was found not in compliance with the following requirement(s): F221, F226, F248, F281, F323, F425, F465 and F514.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, record review, and interview, the provider failed to ensure a physician's order was obtained and an appropriate assessment had been done for one of one sampled resident (11) who was using a torso (chest and stomach area) support device. Findings include: 1. Random observations from 8/18/15 through 8/19/15 resident 11 was wearing a torso support device on his upper body. He was limited in movement from his upper body while in his wheelchair with the above device present. Review of resident 11's medical record revealed: *The nurses progress notes documented he had fallen on May 15, 16, 17, 18, and 19, 2015.	F 221		

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

[Signature]

Elaine Permet Holder

9/1/15

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.

SEP 14 2015
CORRECTED

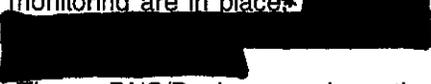
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 221	<p>Continued From page 1</p> <p>*His current care plan showed he was placed in a torso support device on 5/15/15 following a fall. *However they had not received the physician's order for its use until 5/18/15 after the provider's documentation had requested "Dr. _____ May we have an order for a torso support? It is to assist with positioning." *The nurses notes on 5/19/15 in the nurses progress notes showed: -"As a fall prevention, torso support is in place and working well. Released at meals and released while in the bathroom during shift, which is averaging every one to one to hour and one-half."</p> <p>Interview with the administrator and the field services clinical director on 8/20/15 at 10:05 a.m. regarding the torso support device for resident 11 revealed they agreed it had been their expectation the torso support device: *Should not have been placed on the resident prior to a physician's order. *Had not been appropriately evaluated as a restraint or accident/hazard.</p> <p>Review of the provider's 2013 Restraint Evaluation and Utilization Guideline revealed: *A restraint should not be applied for purposes of discipline or convenience. *Restraint use should be considered only when other alternatives had been attempted and ruled as not effective and determined by the interdisciplinary team. *The physician's order must include the medical symptoms (of the resident), type of device, when it is to be used, and how long it should be applied. *A physician's order is not enough alone to cause the need for a restraint.</p>	F 221	<p>*Addendums noted with an asterisk per 9/28/15 by email from facility administrator. NPN/SPD00H/EL</p> <p>F221 Need to ensure physician's order obtained for use of torso support device -A physician's order and restraint assessment have been obtained for the use of a torso support for resident #11 -All residents for whom devices that constrict ability to move have the potential to be affected by the identified practice. -Licensed staff have been educated on the protocol for the placement and use of restrictive devices/restraints as of 9/10/15. -Weekly audits x 3 months for all residents who have a restrictive device in place will be conducted to ensure consent/orders and proper monitoring are in place.</p> <p></p> <p>-The DNS/Designee is the responsible party. -Corrective action will be completed by 10/09/2015</p> <p>→ DNS/Designee to conduct audits and report results monthly to Quapi Committee. NPN/SPD00H/EL</p>	<p>* 10/09/15 NPN/SPD00H/EL</p>
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<p>F 226 F 226 SS=E</p>	<p>Continued From page 2 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625</p> <p>A. Based on interview, record review, and procedure review, the provider failed to report falls with injury to the state reporting agency for two of seven sampled residents (3 and 8) with falls. Findings include:</p> <p>1. Review of resident 3's medical record revealed the following falls had occurred: *She fell on 11/15/14 at 7:28 p.m. in the courtyard outside the secured unit. -She had limited movement and discomfort in her right arm. -X-rays showed a fracture of the right humerus (upper arm.) *She fell on 3/28/15 at 9:43 p.m. in the courtyard outside the secured unit. -Swelling was noted to her right hand. -X-rays revealed a fracture of a bone in the fourth finger of her right hand. *She fell on 6/10/15 at 4:00 a.m. in her room and hit her head.</p> <p>Interview on 8/20/15 at 10:05 a.m. with the administrator and the field services clinical director regarding resident 3's falls revealed:</p>	<p>F 226 F 226</p>	<p>F226 Need to report events with injury timely to SD Dept of Health Investigation has been completed into resident incidents for R3 and R8. Reference check records for employees D, E have been obtained. Employee F is no longer employed with the facility. -All residents have the potential to be affected by the identified practice. -All staff have been educated (as of 9/10/15) of the requirement to report incidents of potential abuse/neglect immediately to the ED or designee in the absence of the ED and all reports of abuse/neglect will be reported to the appropriate state agency in a timely manner. The ED or designee will conduct all investigations to include interviews with employees, visitors, or residents who may have knowledge of the alleged incident. - As of 09/01/2015 all candidates are utilizing an online application process which ensures reference checks are complete prior to employment start date. Reference checks are stored electronically. ED/designee will audit all new employees for reference checks weekly times 4, thereafter monthly times 3. Results will be reported to QA committee. <i>MONTHLY</i> Cont. <i>NPN/SDDOT/EL</i></p>	
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F 226	<p>Continued From page 3</p> <p>*It was the expectation serious or unknown injuries were to be reported to the state reporting agency.</p> <p>*No explanation was given for the reason the above referenced falls were not reported.</p> <p>Surveyor 33265</p> <p>2. Interview and record review on 8/20/15 at 10:45 a.m. with the administrator and the field service clinical director regarding the reporting of resident 8's fall with injury to the Department of Health revealed they agreed:</p> <p>*She had fallen on 11/7/14, and stated her lower right leg hurt, but she had full mobility.</p> <p>*She complained of pain in the right ankle on 11/8/14.</p> <p>*On 11/9/14 the right ankle was swollen and bruised.</p> <p>*On 11/10/14 her physician made rounds and noted the ankle pain.</p> <p>*On 11/12/14 her the pain in her right ankle continued. An appointment for her to be seen was made for the next day.</p> <p>*She had x-rays taken and a fractured bone in the right ankle was documented on 11/13/14.</p> <p>*The Department of Health was not notified of the fall with injury.</p> <p>3. Review of the provider's undated reporting instructions for the SD DOH revealed:</p> <p>**Those falls that involve injury of a serious nature should be reported.</p> <p>*If a fall occurs and the provider determines there were no injuries at the time but later there is discovery of an injury and it is of a serious nature, than the fall should be reported."</p> <p>Review of the provider's 6/17/15 Accident Investigation procedure revealed:</p>	F 226	<p>-Random weekly audits x 3 will be conducted x 3 months of incident reports to ensure any allegations of abuse or neglect have been reported to the ED or designee in a timely manner, reported to the appropriate state agency and have been thoroughly investigated. Any required re-education will be conducted at that time.</p> <div style="background-color: black; width: 100%; height: 100%; margin-top: 10px;"></div> <p>→ ED/Designee will complete audits and report result to Quapi committee monthly. NPN/SDDOH/EL</p>	<p>* 10/09/15 NPN/SDDOH/EL</p>
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F 226	<p>Continued From page 4</p> <p>*"When accidents or incidents are reported, they should be thoroughly investigated and evaluated. *Recommendations should be developed to make changes so that a similar type of accident can be prevented in the future."</p> <p>B. Based on record review, interview, and policy review, the provider failed to complete a reference check for three of five newly hired employees (D, E, and F). Findings include:</p> <p>1. Review of the employee E's personnel file revealed: *She had been hired on 5/12/15. *There was no documentation in her file regarding the results of a completed reference check.</p> <p>2. Review of employee D's personnel file revealed: *He had been hired on 5/26/15. *There was no documentation in his file regarding the results of a completed reference check.</p> <p>3. Review of employee F's personnel file revealed: *She had been hired on 5/26/15. *There was no documentation in her file regarding the results of a completed reference check.</p> <p>4. Interview on 8/20/15 at 11:30 a.m. with the administrator revealed: *It was the expectation that references were checked on all new applicants. *He was unable to provide confirmation or documentation references had been checked on the above employees.</p>	F 226		
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<p>F 226</p> <p>F 248 SS=E</p>	<p>Continued From page 5</p> <p>Review of the provider's 10/24/13 HR-208 Policy regarding abuse, neglect, injuries of unknown origin, and misappropriation of resident's property revealed: "All applicants for employment in the Company shall, at a minimum, have the following screenings conducted: *1. Reference checks with current and/or past employer." 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on interview, record review, and policy review, the provider failed to: *Ensure activities were being conducted for five of five randomly interviewed residents on weekends. *Ensure one-to-one activities were being offered to one of one resident (6) who was bed bound. Findings include: 1. Group interview on 8/18/15 at 10:30 a.m. with five random residents revealed: *They had complaints of not enough activities on weekends. -The only activity offered had been church. *They wanted structured group activities to be led by an individual on the weekends.</p>	<p>F 226</p> <p>F 248</p>	<p>F248 Activities - 5/5 identified residents were provided updated activities schedules with structured weekend activities. residents' 1:1 schedule was updated.</p> <p>- As of [redacted] Staff has been educated on providing structured activities on weekends and holidays. 1:1 Schedule and participation documentation has been updated as of [redacted] → 09/10/15</p> <p>- AD will conduct participation audit weekly times four, thereafter monthly times three. Results will be reported to QA committee. monthly</p> <p>- Corrective action will be completed by 10/09/2015</p> <p>→ An audit of all residents was completed on 09/10/15.</p> <p>→ activities</p>	<p>* 10/09/15 NPN/SDDO/H/EL</p> <p>NPN/SDDO/H/EL</p> <p>NPN/SDDO/H/EL</p> <p>NPN/SDDO/H/EL</p> <p>NPN/SDDO/H/EL</p> <p>NPN/SDDO/H/EL</p>

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F 248	<p>Continued From page 6</p> <p>Interview on 8/20/15 at 9:00 a.m. with the activities director regarding weekend activities revealed: *She was aware that was a concern by residents. *The provider used to have volunteers to lead the activities but now had few. *The manager-on-duty was in charge of weekend activities. *It was a challenge to get weekend staff to provide documentation on activities actually provided or lists of those residents who had attended. *Movies were to be offered as an activity on weekends, but staff would often forgot to start the movie or notify residents it was showing.</p> <p>Interview with the administrator and the field services clinical director on 8/20/15 at 10:05 a.m. regarding weekend activities revealed they agreed: *There needed to be group activities offered on weekends for those residents wishing to attend. *Those activities needed to be more organized. *Staff needed to communicate with residents so they would be informed if they wanted to attend. *Staff needed to ensure those activities needed to be completed as scheduled and resident attendance taken.</p> <p>2. Observation and interview on 8/19/15 at 1:00 p.m. with resident 6 in her room revealed she: *Was laying in her bed watching TV. *Was able to move her hands somewhat but with great difficulty. *Had a disease that caused her muscles to waste away, leaving her bed bound and unable to move her body on her own. *Any body movement was extremely painful so</p>	F 248		

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F 248	<p>Continued From page 7</p> <p>she would remain in bed.</p> <p>*Had been on hospice (end of life care) since May 2015.</p> <p>*Had family that came to visit her on weekends.</p> <p>*Would interact with staff when they came in to feed her or occasionally stopped in.</p> <p>*Would rarely get one-to-one activities in her room with staff.</p> <p>*Would get sad at times when she had no visitors during the week.</p> <p>*Used her phone and TV mostly for activities due to limited movement.</p> <p>Review of resident 6's medical record revealed from March 27 through 8/11/15 only thirteen one-to-one activities had been provided to the resident.</p> <p>Review of the activities calendar for August 2015 revealed activities to have been offered on weekends were coloring, movies, Yahtzee, TV and church.</p> <p>There were no record of attended group activities that could be provided to this surveyor as requested regarding weekend activities.</p> <p>Interview on 8/20/15 at 9:00 a.m. with the activities director regarding weekend activities revealed she would rarely offer one-to-one activities with hospice residents. It was her experience hospice residents required less mental stimulation.</p> <p>Interview and with the administrator and the field services clinical director on 8/20/15 at 10:05 a.m. regarding resident 6's one-to-one activities revealed they agreed:</p> <p>*That was an area of concern.</p>	F 248			

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F 248	Continued From page 8 *She needed one-to-one activities provided from staff since she was unable to leave her room. *Hospice residents in general would be in great need of one-to-one activities.	F 248		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, record review, and policy review, the provider failed to ensure a physician's order was verified and followed for medications for one of one random resident (15). Findings include:</p> <p>1. Observation and interview on 8/19/15 at 8:12 a.m. with licensed practical nurse (LPN) A while she had been preparing medications for resident 15 revealed: *There was: -One 10 milligrams (mg) citalopram (for depression) tablet in her morning medication packet. -One 20 mg citalopram tablet in her evening medication packet. *The physician had ordered the citalopram to be reduced to 10 mg daily on 8/10/15. *She called the pharmacy and reported the multiple doses of 20 mg and 10 mg citalopram. *She informed the pharmacy resident 15 was to receive 10 mg at bedtime. *She placed both doses of the citalopram in the medication cart for destruction when another</p>	F 281	<p>F281 Need to verify physician's order for medication. -Review of R15's ordered medication regimen in conjunction with physician's orders and medications received/dispensed from facility Automatic Dispensing Unit (ADU) was done on: 09/10/15 to assure medications administered correctly per physician's orders. All residents receiving medications have the potential to be affected by the identified practice. Licensed nursing staff and medication aids were educated on 9/10/15 on verifying correct medications are being delivered according to physician's orders and are being correctly dispensed via the ADU.</p> <p><i>see next page!</i></p> <p>-DNS/Designee is the responsible party. -Corrective action will be completed by 10/09/2015</p>	<p>* 10/09/15 NPN/SDDOH/EL</p>

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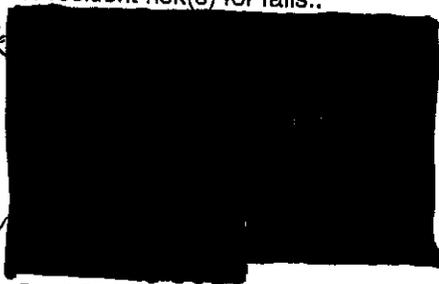
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F 281	<p>Continued From page 9 nurse was available to witness the destruction.</p> <p>Review of the 8/18/15 dispense report and the medicine dispense history reports from 8/10/15 through 8/18/15 revealed 10 mg and 20 mg tablets had been filled in resident 15's medication packets daily.</p> <p>Review of resident 15's medical record revealed: *An order on 7/13/15 for citalopram 20 mg by mouth at bedtime. *An order on 8/10/15 to reduce the citalopram to 10 mg every day. *Signatures indicated 10 mg of citalopram had been administered daily from 8/11/15 through 8/18/15. *No documentation the citalopram had been given on 8/10/15. *No citalopram was listed as having been destroyed on her drug disposition record from 8/10/15 through 8/18/15.</p> <p>Observation on 8/19/15 at 2:30 p.m. with LPN B of resident 15's citalopram in a basket for destruction in the medication room revealed: *One packet marked 8/10/15 evening contained one 20 mg citalopram tablet. *One packet marked 8/13/15 morning contained one 10 mg citalopram tablet. *One packet marked 8/14/15 morning contained one 10 mg citalopram tablet.</p> <p>Interview on 8/19/15 at 2:32 p.m. with the director of nursing regarding the citalopram doses for resident 15 revealed she agreed: *The physician had ordered her to receive 10 mg of citalopram daily. *The pharmacy had continued to fill 10 mg and 20 mg of citalopram daily for the resident.</p>	F 281	<p>*Contracted pharmacist in any issues surrounding dispensing of medications via ADU, and provides direction in addressing any discrepancies with pharmacy as applicable. 10/09/15 NPN/SDO/et/c</p> <p>DNS/Designee will conduct random weekly audits on 5 randomly selected medication/dispense records weekly times 4 then monthly times 3 months on residents to ensure medications are being correctly administered according to physicians orders and being dispensed correctly via the ADU. DNS/Designee will report audit results to monthly Quapi meeting. NPN/SDO/et/c</p>	
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F 281	<p>Continued From page 10</p> <p>*She would have expected the nurses to verify what dose had been ordered by the physician and call the pharmacy with any discrepancies.</p> <p>*She would have expected there would have been documentation of all destroyed medications.</p> <p>*There were 10 mg tablets of citalopram dated 8/13/15 and 8/14/15 in the medication destruction basket indicating the resident had not received the ordered dose on those two days.</p> <p>*There was no documentation of any doses of citalopram having been destroyed from 8/10/15 through 8/18/15.</p> <p>*There was no documentation she had received any citalopram on 8/10/15.</p> <p>*There was no way to prove she had been receiving the physician's intended dose from 8/10/15 through 8/18/15.</p> <p>*The nursing staff did not follow their policy and procedure for administration of medications.</p> <p>Review of the provider's May 2012 Administration Procedures For All Medications policy revealed: **"Prior to removing the medication from the container check the label against the order on the MAR." **"After administration...document administration in the MAR." **"Once removed from the package or container, unused or partial doses should be disposed of in accordance with the medication destruction policy."</p> <p>Review of the provider's May 2012 Disposal of Medications and Medication-Related Supplies Medication Destruction policy revealed "unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed."</p>	F 281			

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F 323 F 323 SS=E	Continued From page 11 483.25(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: 35625 Based on observation, record review, interview, and policy review, the provider failed to: *Thoroughly investigate multiple falls and ensure appropriate interventions were put into place after each fall occurred to attempt to prevent further falls from happening for one of seven sampled residents (3). *Provide notification to the physician after each fall for one of seven sampled residents (3). Findings include: 1. Observation on 8/18/15 at 11:45 a.m. of resident 3 revealed: *She was using a Merry Walker (enclosed frame walker and chair) to ambulate in the corridor. *Two staff approached the resident to assist her into the dining room. *She attempted to briefly stand by herself while staff were preparing her for transfer. *She was assisted by two staff with the use of a gait belt (a device placed around the waist to assist in moving an individual from one position to another) to her table in the dining room. *There was a pressure sensor alarm placed on	F 323 F 323	F323 Need to thoroughly investigate multiple falls for resident -Causal factors for falls were identified for R3. Resident #3 no longer resides in facility. -All residents at risk for falls have the potential to be affected by the identified practice. -All staff have been educated (as of 9/10/15) on identifying causal factors for residents with falls and the facility's protocol for assessment, care planning, evaluation, notification, documentation and communication of resident risk(s) for falls..  -DNS/Designee is the responsible party.  NPNISDDOT/EL	* 10/09/15 NPNISDDOT/EL

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F 323	<p>Continued From page 12</p> <p>her chair to alert staff of her attempts to stand on her own. *She was unable to answer questions from this surveyor.</p> <p>Review of resident 3's medical record revealed: *A diagnosis of dementia (a disease that causes long term and gradual decrease in ability to think and remember.) *She had been identified through assessment she was at risk for falls. *She had twelve falls recorded on the fall log sheet from 8/29/14 through 8/2/15. -No documentation was provided to identify if the falls were witnessed or unwitnessed. -Nine falls without injury appeared to have occurred. *She fell on 11/15/14 at 7:28 p.m. in the outdoor area of the secured unit. -X-rays showed a right humerus (upper arm) fracture. *She fell on 3/28/15 at 9:43 p.m. in the outdoor area of the secured unit. -X-rays showed a fracture to a finger on her right hand. *The nursing progress notes from 6/10/15 at 7:14 a.m. revealed the resident had struck her head with a fall at 4:00 a.m. on that date. *There was no documentation a physician had been notified after five of the twelve falls (3/28/15, 6/10/15, 6/21/15, 7/12/15, and 7/30/15).</p> <p>Review of the 6/19/15 risk for falls assessment revealed: -She had a score of sixteen. -A score above ten meant the resident was at increased risk for falls.</p> <p>Review of resident 3's 6/19/15 Minimum Data Set</p>	F 323	<p>*DNS/Designee will conduct audits for all falls x 3 months including Post Fall investigations, to ensure casual factors have been identified and proper interventions have been enacted and are being assessed to mitigate future falls. DNS/Designee will report results to monthly Quapi meeting. The Golden living falls management Guidelines that includes notification of physician following a residents fall was reviewed with licensed nursing staff on 09/10/15.</p> <p>NPN/SDRott/EL</p>	

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F 323	<p>Continued From page 13 (MDS) assessment revealed: *A Brief Interview for Mental Status (test to determine recall and memory ability) score of three out of fifteen indicated her thinking and decision making abilities were severely impaired. *She needed assistance of two staff persons to: -Walk in the corridor. -Walk on and off the unit. -Walk in her room. -Move in bed. -Transfer. -Use the bathroom. *Falls had been identified as an area of concern.</p> <p>Review of resident 3's current care plan revealed: *On 2/18/15 an intervention for one staff assist with transfers. *On 6/22/15 an intervention to ambulate with a walker and two staff assist and to follow with the wheelchair. *Two out of the thirteen fall interventions had been put into place after the resident had fallen. *There had been no review noted or additional interventions put into place following ten falls between 8/29/14 through 8/2/15.</p> <p>Review of resident 3's Post Fall Analysis/Plan computerized form and fall log revealed twelve falls on the following dates from 8/29/14 through 8/2/15: *Eleven of the falls had documentation she had impaired safety awareness and judgement, and a history of falls. *On 8/29/14: -Was ambulating in the dining room after breakfast, lost her balance, and strength. *On 11/15/14: -Was ambulating in the courtyard, lost her balance, slipped, and fell face first into the snow.</p>	F 323		

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F 323	Continued From page 14 -Had discomfort in area of trauma and a change with her range of motion. -No documentation as to the length of time she was outside. *On 1/9/15: -Lost her balance in her room while ambulating without assistance. *On 1/22/15: -Lost her balance and strength when she stood up from the wheelchair, and fell to the floor in the dining room. *On 3/11/15: -Lost her balance while ambulating in room. *On 3/28/15: -Lost her balance and slipped while ambulating in the courtyard. -Was outside in the dark. -Swelling noted on the right hand with a change in range of motion. -She told staff, "I was trying to get to the car." -No documentation as to the length of time she was outside. *On 4/8/15: -Lost her balance while ambulating in her room. *On 6/10/15: -Lost her balance while walking back from the bathroom with staff.. *On 6/21/15: -Lost strength while doing usual activities in the corridor. *On 7/12/15: -Rolled out of bed while attempting to self-transfer. *On 7/30/15: -Lost her balance while ambulating in the corridor and was anxious and irritable. *On 8/2/15: -Was attempting to self-transfer while in the corridor.	F 323			

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F 323	<p>Continued From page 15</p> <p>-Experienced discomfort in the area of trauma (right side of her face.)</p> <p>-No documentation any interventions were initiated following the above falls.</p> <p>*Additional documentation regarding the investigation of the above falls was requested, but no documentation was provided up until the end of the survey.</p> <p>Interview on 8/20/15 at 9:45 a.m. with licensed practical nurse B regarding resident 3 revealed the resident:</p> <p>*Would occasionally get into a frantic and anxious state where she needed to move around the building.</p> <p>*There was no documentation provided that showed additional interventions or monitoring that was put in place when the resident was anxious.</p> <p>Interview on 8/20/15 at 10:05 a.m. with the administrator and the field services clinical director regarding resident 3 revealed:</p> <p>*It was the expectation the physician would be notified after a resident fall regardless of injury or not.</p> <p>*The expectation was that all required events were reported to the SD DOH including serious or injuries of unknown origin (did not know how or what had happened).</p> <p>*Acknowledged each fall investigation should have been completed to ensure or prevent a decrease in future falls.</p> <p>*The door to the courtyard in the secured unit was alarmed.</p> <p>-It would not be unusual for a resident to have been in the courtyard.</p> <p>-No explanation was given to the question regarding each of the two falls in the courtyard that had occurred in the winter and after dark.</p>	F 323		
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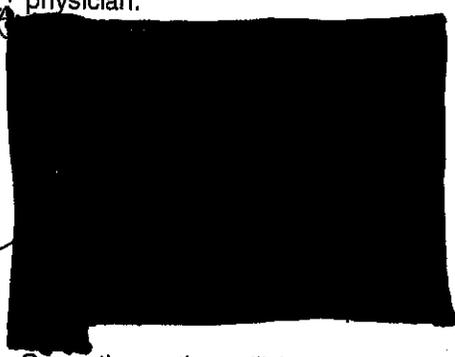
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F 323	Continued From page 16 Interview on 8/20/15 at 11:45 a.m. with the secured unit director revealed: *The door to the courtyard was unlocked but would alarm after dark. *No explanation was given to the question regarding the timeliness of the staff in addressing the alarm on the door. Review of the provider's 6/17/15 Accident Investigation procedure revealed: *"When accidents or incidents are reported, they should be thoroughly investigated and evaluated. *Recommendations should be developed to make changes so that a similar type of accident can be prevented in the future." Review of the provider's 6/26/15 Falls Management Guideline revealed: *"The physician and resident's representative is notified. *Appropriate interventions are implemented. *Care plan is updated."	F 323			
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425			

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F 425	<p>Continued From page 17 the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, record review, and policy review, the provider failed to ensure the correct dose of a medication was being dispensed from an automated medication machine for one of one random resident (15). Findings include:</p> <p>1. Random observations from 8/18/15 at 10:30 a.m. through 8/19/15 at 9:28 a.m. of licensed practical nurses (LPN) A, B and H during medication administration revealed: *There was an automated machine that filled individual sealed packets with prescribed medications for each resident. *Each packet from the automated system was filled with medications by the times they were ordered to be given.</p> <p>Observation on 8/19/15 at 8:12 a.m. with LPN A regarding medications for resident 15 revealed: *One 10 milligrams (mg) citalopram (medication for depression) tablet was in the morning packet. *One 20 mg citalopram tablet was in the evening packet.</p> <p>Review of resident 15's complete medical record</p>	F 425	<p>F425 Need to ensure the correct dose of medication was being dispensed from Automatic Dispensing Unit -On 09/10/2015 medication regimen reviewed in conjunction with medications delivered via Automatic Dispensing Unit (ADU) were reviewed for R15 to assure correct dosing and administration of medications. the facility. -All residents receiving medication have the potential to be affected. -Licensed staff have been educated (as of 9/10/15) on medication errors and medication administration to include obtaining correct medications/dosing as ordered by physician.</p> <p>Corrective action will be completed by 10/09/2015</p>	<p>*10/09/15 NPN/SPD/EL</p>	

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F 425	<p>Continued From page 18 revealed:</p> <ul style="list-style-type: none"> *An order on 7/13/15 for 20 mg of citalopram at bedtime. *On 8/10/15 the physician decreased the citalopram to 10 mg every day. *No citalopram was listed as having been destroyed on the drug disposition record from 8/10/15 through 8/18/15. <p>Review of the medicine dispense history reports from 8/10/15 through 8/18/15 regarding resident 15 revealed the automated medication machine had dispensed each day:</p> <ul style="list-style-type: none"> *One 10 mg citalopram tablet in the morning packet. *One 20 mg citalopram tablet in the evening packet. <p>Observation on 8/19/15 at 2:30 p.m. with LPN B of the medications waiting for destruction in the medication room revealed:</p> <ul style="list-style-type: none"> *One packet marked 8/10/15 evening contained one 20 mg citalopram tablet. *One packet marked 8/13/15 morning contained one 10 mg citalopram tablet. *One packet marked 8/14/15 morning contained one 10 mg citalopram tablet. <p>Interview on 8/19/15 at 9:10 a.m. with LPN B revealed the nurses were to have faxed physician's orders for medications to the pharmacy.</p> <p>Interview on 8/19/15 at 1:10 p.m. and on 8/20/15 at 10:00 a.m. with consultant pharmacist C regarding resident 15's citalopram revealed:</p> <ul style="list-style-type: none"> *The provider was to have ensured the pharmacy had the current physician's orders. *The pharmacy entered the physician's orders 	F 425	<p>*DNS/Designee will conduct random weekly audits x 4; then monthly times 3 of 5 new or changed orders to assess that medication administration was conducted correctly and any discrepancies of medications received from ADU are reported timely. Negative findings will be addressed at that time. DNS/Designee will report results to monthly Quapi Meeting.</p> <p>NPN/SPDOH/EL</p>	
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F 425	<p>Continued From page 19</p> <p>into the computerized system for dispensing.</p> <p>*Medications ordered to be given every day were dispensed in the morning for this facility, unless it had been requested or ordered for a different time.</p> <p>*He would have expected the provider to have called the pharmacy to change medication times when needed.</p> <p>*He had not identified any problems with the citalopram administered in the morning rather than the evening.</p> <p>*He confirmed:</p> <ul style="list-style-type: none"> -The pharmacy had received the 8/10/15 clinic referral by fax. -On 8/10/15 the physician had ordered the citalopram to be reduced to 10 mg every day. -The pharmacy had continued to dispense 10 mg and 20 mg tablets of citalopram every day from 8/10/15 through 8/18/15. <p>*He stated:</p> <ul style="list-style-type: none"> -There was "No question that both pills were being dispensed." -"I'm glad you caught this. Who knows how long it could have continued until it was caught." <p>Interview on 8/19/15 at 2:32 p.m. with the director of nursing regarding resident 15's citalopram revealed she agreed:</p> <ul style="list-style-type: none"> *On 8/10/15 the physician had ordered to reduce the citalopram to 10 mg daily. *The pharmacy had continued to fill both the 10 mg and the 20 mg tablets daily for that resident. <p>Interview on 8/20/15 at 11:00 a.m. with the administrator and the field services clinical director regarding resident 15's citalopram revealed they would have expected the correct ordered dose of citalopram to have been dispensed by the pharmacy.</p>	F 425		

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F 425	Continued From page 20	F 425		
F 465 SS=D	<p>Review of the provider's May 2012 Consultant Pharmacist Services Provider Requirements policy revealed the consultant pharmacist was to have:</p> <p>*Helped to "identify, communicate, address, and resolve concerns and issues related to the provision of pharmacy services."</p> <p>*Evaluated "the process of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, and using and/or disposing of all medications, biological, and chemicals."</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation and interview, the provider failed to ensure ceiling tiles were repaired and maintained appropriately in one of two dining rooms. Findings include:</p> <p>1. Observation and interview on 8/20/15 at 11:00 a.m. in the main dining room with the administrator regarding the ceiling tiles revealed: *Several ceiling tiles in the main dining room had been wet from a leak above and were heavily stained with a brown and black color and had</p>	F 465	<p>ceiling tile was replaced 9/18/15 air conditioner water overflow pan was repaired on 9/18/15. An audit was conducted on 9/10/15.</p> <p>NPN/SDDOH/EL</p> <p>F465 Sanitary Environment (Ceiling tiles)</p> <p>[REDACTED]</p> <p>* 10/9/15 NPN/SDDOH/EL</p> <p>* monthly NPN/SDDOH/EL</p> <p>[REDACTED]</p> <p>NPN/SDDOH/EL</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON			STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042	
(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 465	Continued From page 21 been affixed with a metal washer and screw combination. *Those screws were holding the tiles in place. *Wet tiles could lead to mold and would be an area of concern as it affected a large number of residents. *He agreed they needed to be replaced.	F 465		
F 514 SS=D	There was no preventative maintenance plan that addressed the repair of ceiling tiles. 483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review and interview, the provider failed to have an integrated care plan between the facility and hospice for two of two sampled residents (3 and 6) receiving hospice care. Findings include: Surveyor 35237	F 514	F514 <i>Need for integrated care plan between facility and hospice provider</i> The care plan for R6 was reviewed and updated as of 09/10/2015 to include integration of hospice goals and interventions into facility's plan of care. R3 no longer resides at facility. All residents receiving end of life care through hospice services have the potential to be affected by this practice. Care plans for all residents residing in facility receiving hospice care services have been reviewed and updated to illustrate integration of services as of 09/18/2015. Facility staff were educated on 9/10/15 on the need for integration between facility and hospice plans of care to identify/differentiate responsibilities of interventions. SSD or Designee will be responsible party. All care plans of residents receiving hospice services will be audited weekly x 4 weeks; monthly x 3 months to assure care plans correctly illustrate integration of services.* 	* 10/9/15 NPN/SSD/ST/EL

DNS/Designee will report result to monthly QAPI meeting. NPN/SSD/ST/EL

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042
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F 514	<p>Continued From page 22</p> <p>1. Review of resident 3's medical record revealed: *She was admitted to hospice services on 6/12/15. *The 6/12/15 hospice care plan revealed a goal of a nursing plan of care that would meet the resident's needs. *The 6/25/15 provider's care plan revealed no distinction between the hospice and provider responsibilities.</p> <p>2. Review of resident 6's medical record revealed: *Her current 8/18/15 care plan had not differentiated between hospice care responsibilities and the provider's care responsibilities. *Her 7/29/15 hospice care plan revealed a nursing plan of care was to have been established that met the resident's needs.</p> <p>3. There was no policy on care plans per the field services clinical director.</p> <p>Interview and with the administrator and the field services clinical director on 8/20/15 at 10:05 a.m. regarding integrated care plans between hospice and the provider revealed they agreed: *There needed to be a combined interdisciplinary care plan. *The roles of the provider and hospice needed to be defined so each knew what care they were providing to the resident.</p> <p>Surveyor: 35625</p>	F 514		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435053	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/19/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/19/15. Golden LivingCenter-Madison 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 and the Fire Safety Evaluation System (FSES) dated 8/19/15 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 020 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the provider failed to maintain the 60 minute fire resistive rating of one randomly observed dumbwaiter door assembly at the main level B wing service area. Findings include:	K 020		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Construction Manager	(X6) DATE 9/14/15
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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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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042
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K 020	Continued From page 1 1. Observation at 11:00 a.m. on 8/19/15 revealed the corridor door to the dumbwaiter on the main level B wing service area did not have a label to identify the fire resistive rating. Review of the previous life safety code data indicated that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct deficiencies identified in K000.	K 020		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and record review, the provider failed to maintain a one hour fire resistive path of egress from the basement to the exterior of the building. One of two basement stairways (north stairway) discharged into the main level corridor system. Findings include: 1. Observation at 1:00 p.m. on 8/19/15 revealed the north stairway from the basement discharged into the main level corridor system. A continuous	K 033		F

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH ST MADISON, SD 57042
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K 033	<p>Continued From page 2</p> <p>one hour fire resistive path of egress was not provided to the exterior of the building. Review of previous life safety code survey data indicated that condition had existed since the original construction.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of deficiencies identified in K000.</p>	K 033		

ORIGINAL

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/20/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MADISON	STREET ADDRESS, CITY, STATE, ZIP CODE 718 NE 8TH STREET MADISON, SD 57042
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S 000	Initial Comments Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/17/15 through 8/20/15. Golden LivingCenter-Madison was found not in compliance with the following requirement(s): S210.	S 000	*Addendums noted with an asterisk per 9/28/15 per email with facility administrator. NPN/DDOH/EL	
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 Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to ensure three of five sampled employees (D, F, and G) were found free from communicable diseased by a licensed healthcare provider prior to employment. Findings	S 210	S210 Employee Health Program - Employee D and G Health Screens were completed 09/18/2015. Employee F is no longer employed with the facility - A health screen audit was conducted to identify other potentially affected employees - Hiring managers were educated on the Onboarding process. The hiring manager will ensure that the Health Screen forms are completed as part of the onboarding process. ED/designee will sign off on Onboarding checklist for all new employees. Corrective action will be complete 10/09/2015 - ED/designee will audit Onboarding checklist weekly times 4, monthly times three. Results will be reported to QA committee.	*10/9/15 NPN/DDOH/EL

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

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If continuation sheet 1 of 2

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/20/2015
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S 210	<p>Continued From page 1</p> <p>include:</p> <p>1. Review of the employee file for dietary specialist G revealed: *His hired date was 4/28/15. *An employee health information document had been started but was left incomplete. -The date of completion was blank. -There was no information filled in regarding immunization status. -It was not signed by the new employee or reviewed by a licensed health professional.</p> <p>Review of the employee file for certified nursing assistant D revealed: *His hired date was 5/26/15. *There was no documentation of a health evaluation in his file.</p> <p>Review of the employee file for nursing assistant F revealed: *Her hired date was 5/26/15. *There was no documentation of a health evaluation in her file.</p> <p>Interview on 8/20/15 at 11:30 a.m. with the administrator confirmed completed health evaluations had not been documented for the above employees.</p> <p>Review of the provider's 1/5/15 Health Requirements policy revealed: *A health review was required. *The health review was to be completed after the employee had accepted the conditional job offer and prior to the first day of work.</p>	S 210		