

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

ORIGINAL

PRINTED: 02/25/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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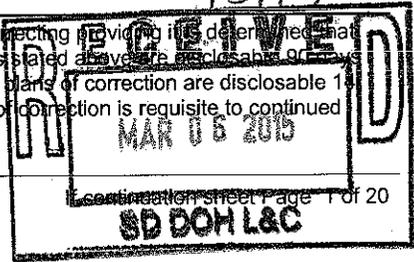
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS Surveyor: 32335 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/9/15 through 2/11/15. Golden LivingCenter - Pierre was found not in compliance with the following requirement(s): F176, F281, F364, F371, and F441.	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 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, there provider failed to ensure residents doing self-administration of medications were able to understand and follow the steps involved for three of eight sampled residents(4, 8, and 10) with orders to do self- administration of medications. Findings include: 1. Observation on 2/11/15 at 9:55 a.m. in resident 10's room with registered nurse (RN) I revealed: *A medication cup was sitting on resident 10's bedside stand with five pills in it. *RN I had no idea where resident 10 was. She stated "he may have left the building, he does that without telling us sometimes." *RN I stated she had left the medications there for the resident to take earlier in the morning.	F 176		F176 1. All residents who can self-administer medications are at risk. Resident's 4,8 & 10 self-administration of medication assessments were reviewed and revised to reflect that they are unable to safely self-administer medications. The facility does ensure residents doing self-administration of medications are able to understand and

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jami Koste</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3/5/15</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 15 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 176	<p>Continued From page 1</p> <p>*The door to his room was wide open. *The other resident in the room was asleep in a recliner.</p> <p>Interview on 2/11/15 at 10:00 a.m. with the director of nursing (DON) revealed: *She agreed that resident had at times left the building without letting anyone know. *She believed the resident was able to self-administer his medications.</p> <p>Review of the resident 10's complete medical record revealed: *Notes on the care plan with the printed date of 3/6/14, under the focus concerning self-administration of medications stated: -"Resident will frequently leave the facility without taking his medications." -May self-administer nebulizer treatment after set up by nurse dated 8/5/14. -Interventions included nursing was to ensure all medications were taken by the resident. *Physician's order dated 12/16/13 stated the resident may self-administer oral medications and insulin after set-up by nursing. There was no physician order for self-administration of nebulizer treatments (medication administered by a machine that is inhaled through a mask). *One Self-Administration of Medications form completed by an interdisciplinary team on 11/13/13 listed oral medications and insulin. No other form was provided that included self-administration of nebulizer treatments. *The medication administration record: -Listed five oral medications to be given at 8:00 a.m. -Had no order for self-administration of any medications.. -Had no order for nebulizer treatments.</p>	F 176	<p>follow the steps involved in order to safely self-administer medications.</p> <p>2. The Director of Nursing Services (DNS) will in-service the interdisciplinary team, nurses and medication aid on the self-administration of medication policy and procedures to ensure residents are safe and appropriate to self-administer medications. In-service will be completed no later than March 13, 2015.</p> <p>3. The DNS or designee will audit 4 random residents that self-administer medications weekly X 4, then monthly X 3 to ensure that residents are able to safely self-administer medications. Results of audits will be reported by the DNS and discussed at monthly Quality Assurance and Process Improvement (QAPI) meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. March 31, 2015</p>		

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F 176	<p>Continued From page 2</p> <p>2. Record review of resident 8's complete medical record revealed: *She was considered cognitively, physically, and visually able to safely self-administer medication (identified as a nebulizer treatment) only after set-up by nursing. *Her Brief Interview for Mental Status (BIMS) assessment score dated 1/22/15 on the Minimum Data Set (MDS) assessment form was five which was identified as severely impaired. *The care plan with printed date of 1/28/15 identified her as having severely impaired cognition; was short term memory impaired.</p> <p>Surveyor: 35121 Preceptor: 32331</p> <p>3. Review of the resident 4's medical record revealed: *She was admitted on 1/26/11. *She had diagnoses of senile dementia (loss of mental function) and blindness in the left eye. *A physician's order on 12/12/14 "May self administer nebulizer treatments after set up per nursing."</p> <p>Review of resident 4's Self Administration of Medications form dated 10/1/13 revealed she was able to safely self administer nebulizer treatments cognitively, physically and visually only after set-up by nursing.</p> <p>Review of resident 4's 1/15/15 MDS assessments revealed she: *Was unable to participate in the BIMS, because she was rarely or never understood. *Was severely impaired to make decisions</p>	F 176			

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F 176	Continued From page 3 regarding tasks of daily life. *Used no speech. *Sometimes understood others. *Required total assistance (dependent on others) with activities of daily living. *Had highly impaired vision. Review of resident 4's 1/22/15 care plan revealed: *She was allowed to self-administer nebulizer treatments after set-up by nursing staff. *Goal was to have safe administration of nebulizer treatments. *Interdisciplinary team was to have reviewed her ability to safely administer her nebulizer treatment on a quarterly basis. *No review was found of resident 4's ability to safely self-administer nebulizer treatments by the above team since 10/1/13. Review of the provider's October 2007 Self-Administration by Resident policy revealed: *If a resident desired to self-administer medications an assessment would be conducted by the interdisciplinary team of the resident's cognitive (mental), physical, and visual ability to carry out the responsibility. *Self-administration of medications was identified as a process where the resident could demonstrate how to read the label of the medication container, removed/take correct dose, and document medication taken at the bedside. *There was no discussion of self-medication administration being identified as a resident taking medications that had been set-up by a nurse and left at the bedside.	F 176			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281			

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F 281	<p>Continued From page 4</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: 33265 Based on interview, record review, and policy review, the provider failed to: *Follow the nursing scope of practice (what a nurse can legally do) on pronouncement the of death for one of one sampled deceased resident (15). *Document disposition of a resident's property for one of one sampled deceased resident (15). Findings include:</p> <p>1. Review of resident 15's complete medical record revealed: *A staff nurse was called to the resident's room on 1/28/15 by her daughter. *The resident was noted to be without a heartbeat and respirations at 3:07 p.m. *Another relative was notified of the resident's passing at 3:10 p.m. *The resident's physician was notified of resident's passing at 3:15 p.m. and orders were received to release the body to the funeral home.</p> <p>Interview on 2/11/15 at 4:40 p.m. with the director of nursing (DON) regarding a death in the facility revealed she agreed pronouncing death was outside of the nursing scope of practice.</p> <p>2. Review of resident 15's complete medical record revealed: *An order had been received from the physician to release the resident's body to the funeral home</p>	F 281	<p>F281</p> <p>1. All residents are at risk. No corrective action can be taken for resident 15. Nurses do follow the nursing scope of practice on pronouncement of death for all residents. There is documentation to support the disposition of a resident's property for all residents.</p> <p>2. The DNS will in-service all nurses that the pronouncement of death of a resident is not within a nurse's scope of practice. The DNS will in-service all nurses and the Social Service Coordinator that documentation needs to support the disposition of a resident's property for all deceased residents. In-service will be completed no later than March 13, 2015.</p> <p>3. The DNS or designee will complete audits of deceased residents monthly x 4 to ensure that nurses do not pronounce the death of a resident and to ensure the resident's inventory form supports the disposition of their property after death. Results of audits will be reported by the DNS and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. March 31, 2015</p>	3/31/15

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F 281	Continued From page 5 on 1/28/15. *The resident's body was released to the funeral home on 1/28/15 at 5:05 p.m. *An Inventory of Personal Items form identifying where the resident's personal belongings went after leaving the facility had not been completed. Interview on 2/11/15 at 4:40 p.m. with the DON revealed she agreed there should have been documentation regarding what was done with the resident's belongings after her death. No policy on the death of a resident was received upon request. A 1/14/15 dated training form on steps to follow when there was a death in the provider's facility was provided. The steps included: *Nurse scope of practice was to: -Complete the assessment. -Document findings. -Notify the physician. -Obtain an order to release the body to the funeral home of resident/family choice. There was no reference as to documentation of what was done with the deceased resident's belongings on that form.	F 281			
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364	F364 1. All residents are at risk. Residents 4 & 6 pureed diets are being prepared appropriately to maintain nutritional value. The facility does maintain nutritional value of food for those residents who have a pureed diet.	3/31/15	

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F 364	<p>Continued From page 6</p> <p>Surveyor: 32331</p> <p>Based on observation, interview, and policy review, the provider failed to ensure nutritional value of food was maintained for two of two meal services for two of two sampled residents (4 and 6) who were on pureed (puree consistency) diets. Findings include:</p> <p>1. Interview on 2/10/15 at 11:20 a.m. with cook B revealed he:</p> <ul style="list-style-type: none"> *Had prepared the pureed foods for residents 4 and 6 for the noon meal. *Had pureed the food and had added tap water from the first sink of the three compartment sink to thin the pureed foods for the following: <ul style="list-style-type: none"> -Chili. -Green beans. *Stated he had added tap water until the food was at the right consistency. -How much water had been added depended on what type of food he had been pureeing. <p>Observation on 2/10/15 at the noon meal revealed:</p> <ul style="list-style-type: none"> *Resident 6 received her meal in the secured dementia unit dining room at 12:00 noon that had included the pureed chili and green beans. *Resident 4 received her meal at 12:18 p.m. in the main dining room that had included the pureed chili and green beans. <p>Interview on 2/10/15 at 5:30 p.m. with cook C revealed she:</p> <ul style="list-style-type: none"> *Had prepared the pureed foods for residents 4 and 6 for the evening meal. *Had pureed the food and had added water from a pot on the stove top to thin the pureed food peas. 	F 364	<p>2. The Dietary Services Manager (DSM) will in-service the cooks on how to prepare the pureed diets properly to maintain nutritional value. In-service will be completed no later than March 13, 2015.</p> <p>3. The DSM or designee will conduct audits of dietary services weekly X 4, then monthly X 3 to ensure pureed diets are prepared properly. Results of audits will be reported by the DSM or designee and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audit.</p> <p>4. March 31, 2015</p>	
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F 364	<p>Continued From page 7</p> <p>Observation on 2/10/15 at the evening meal revealed resident 4 received her meal at 6:10 p.m. that had included the pureed peas.</p> <p>Interview on 2/11/15 at 1:40 p.m. with the administrator and the certified dietary manager regarding the residents that received pureed foods revealed: *They would have expected the cooks to have used a liquid with nutritive value such as broth or gravy to the required consistency. *They agreed the addition of the water added no additional nutritional value for the food portions served to those residents on a pureed diet.</p> <p>Review of the provider's undated Pureed Food Preparation policy revealed approved pureed recipes for all pureed diets were to have been used.</p> <p>Lisa Eckstein and Katheryn Adams, Pocket Resource for Nutritional Assessment, 2013 Ed., Chicago, IL., 2013, pp. 103 and 106, revealed for a resident with dysphagia (problems with swallowing) can result in serious health consequences as it can interfere with adequate nutrition and hydration. To minimize swallowing problems, and maximize nutrition, hydration, and quality of life for the resident, dietary modifications involve changes in food and/or liquid texture to help compensate for loss of function, to maintain appropriate nutritional and hydration status, and to reduce the risk of aspiration. Those might include temperature changes and order of food/liquid presentation changes such as moistening and providing a cohesive bolus (to hold an amount together) by adding gravy or sauce.</p>	F 364		

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F 371 F 371 SS=F	Continued From page 8 483.35(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, testing, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for the following: *The wiping cloths used to wipe down the food counters and microwave in the kitchen and 13 of 13 dining room tables (main dining room) had not been placed in a sanitizer solution. *One of one reinforcement bar above the stove in the hood area in the kitchen had a cleanable surface. Findings include: 1. Observation on 2/9/15 in the kitchen from 4:55 p.m. through 5:21 p.m. revealed: *One wet cloth laying on the dirty side of the counter of the three-compartment sink. *A reinforcement bar located in the hood area above the grill and stove had a significant amount of off-white paint chipped off creating an uncleanable surface. -Portions of that reinforcement bar were located	F 371 F 371	F371 1. All residents are at risk. Sanitary conditions are maintained in the kitchen and dining room. The surface above the stove in the hood area has been painted. 2. The DSM will in-service the dietary staff to ensure that sanitizer is being used to disinfect the dining room tables and on all counters in the kitchen, as well as the microwave. Will also educate dietary staff to monitor for items that are uncleanable and to report to DSM when identified. In-service will be completed no later than March 13, 2015. 3. The DSM or designee will complete audits weekly x 4 and then monthly x 3 to ensure that sanitary conditions are maintained in the kitchen and dining room. Results of the audits will be reported by the DSM and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits. 4. March 31, 2015	3/31/15	

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F 371	<p>Continued From page 9</p> <p>directly above the cooking area of the grill. *A bucket that contained a liquid with suds was located on a three-tiered cart located in the dishroom.</p> <p>Interview on 2/9/15 during the above observation with dietary assistant A revealed the bucket located on the above three-tiered cart in the dishroom contained soap. It was used to wipe off the tables in the residents' dining room.</p> <p>Observation on 2/10/15 at 11:25 a.m. with dietary assistant A in the kitchen revealed: *She picked up a wet cloth located on the counter on the dirty end of the three-compartment sink. *She wiped down the microwave with the above wet cloth. *She wiped the food production counter around the microwave with that same cloth. *She then placed that same wet cloth on the counter on the dirty end of the three-compartment sink. *The above wet cloth had not been in a sanitizing solution prior to wiping down the microwave and the food production counter.</p> <p>Observation on 2/10/15 at 12:25 p.m. and at 12:35 p.m. revealed a wet cloth located on the counter next to the dirty end of the three-compartment sink.</p> <p>Observation and interview on 2/10/15 at 12:40 p.m. with dietary assistant A in the dishroom revealed: *A three-tiered cart that contained: -A bucket that contained a liquid with suds. -A cloth was located inside that liquid. *She stated the bucket contained water and soap. *She pointed to an unmarked gallon container of</p>	F 371		

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F 371	<p>Continued From page 10</p> <p>a blue liquid in the dishroom that she had used in the bucket for the soap.</p> <p>*She stated the bucket had been prepared for cleaning the tables after the residents were finished eating their noon meal.</p> <p>Observation, interview, and testing on 2/10/15 at 1:05 p.m. with dietary assistant A and cook C in the main dining room revealed:</p> <p>*The thirteen dining tables were being cleared of dishes.</p> <p>*Those tables were being wiped down with the a cloth from the above bucket that contained suds.</p> <p>*Dietary assistant A and cook C revealed that was how the tables were cleaned after each meal.</p> <p>*This surveyor tested the above bucket with a Hydrion QT-40 quaternary (quat) test strip (a type of special paper), and it tested zero parts per million (ppm).</p> <p>-That test strip needed to have measured at least 150 ppm for proper sanitizing strength.</p> <p>*Interview with dietary assistant A and cook C revealed the above bucket contained water and soap.</p> <p>Interview on 2/10/15 from 3:40 p.m. through 3:55 p.m. with the certified dietary manager (CDM) regarding the kitchen production counters, the microwave, and all the dining tables in the main dining room revealed:</p> <p>*Those areas were being cleaned with a detergent and water.</p> <p>-That detergent was EcoLab Pantastic, a manual warewashing detergent.</p> <p>-The detergent was not a sanitizer.</p> <p>*He had a Sanitizer Bucket Log that was not currently being used.</p> <p>*He stated there should have been EcoLab Oasis 146 Multi-Quat Sanitizer used as the sanitizer.</p>	F 371		

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F 371	<p>Continued From page 11</p> <p>*He confirmed those areas were not being properly sanitized.</p> <p>Review of the provider's undated Product Specification Document of the Oasis 146 Multi-Quat Sanitizer revealed it:</p> <p>*Could be used to sanitize hard, non-porous food contact surfaces such as tables, counters, and food processing equipment.</p> <p>*Was an effective sanitizer on food contact surfaces when used at 150 to 400 ppm active quat.</p> <p>*Was to have been exposed to surfaces as a sanitizing solution for a period of not less than one minute.</p> <p>Interview on 2/11/15 at 8:00 a.m. with an EcoLab customer service representative regarding Pantastic revealed:</p> <p>*It was a detergent only.</p> <p>*The product had no sanitizing properties.</p> <p>2. Interview on 2/10/15 at 12:30 p.m. with the maintenance supervisor and the CDM in the kitchen regarding the reinforcement bar in the hood area above the grill and stove area revealed:</p> <p>*That bar contained chipped paint.</p> <p>*This surveyor was able to easily chip off paint with her fingernail.</p> <p>*They stated the bar was located directly above a cooking area.</p> <p>*They agreed that bar was no longer a cleanable area and chips of paint could potentially fall onto the grill and cross-contaminate food.</p> <p>*That grill was used to prepare fried eggs, pancakes, and fried potatoes.</p> <p>Interview on 2/10/15 from 3:40 p.m. through 3:55</p>	F 371		

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F 371	<p>Continued From page 12 p.m. with the CDM revealed: *The kitchen production counters, microwave, and the dining tables in the main dining room were not being properly sanitized. *He stated all the areas would be wiped down with a sanitizer as soon as possible.</p> <p>Interview on 2/11/15 at 1:40 p.m. with the administrator and the CDM revealed: *They agreed the kitchen production counters, microwave, and the dining tables in the main dining room needed to have been properly sanitized. *They confirmed the reinforcement bar above the grill and stove area was not a cleanable surface and needed to have been repaired.</p> <p>Review of the provider's 2011 Cleaning Dining Areas policy revealed: **Remove tablecloths if needed. *Wash tabletops using a warm water detergent solution; assure that the edges are washed and free of food buildup. *Rinse with a sanitizing solution at the appropriate strength. *Allow to air-dry."</p> <p>Review of the provider's undated Cleaning Microwave Ovens policy revealed: **Remove all glass trays and wheels; wash and sanitize. *Wipe out spills and splatters using a solution of warm water and detergent. *Sanitize with appropriate strength solution."</p> <p>Review of the provider's undated Cleaning Kitchen areas policy revealed areas should be cleaned using a mild-detergent solution then sanitized with appropriate-strength solution.</p>	F 371		

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F 371	Continued From page 13	F 371			
F 441 SS=E	<p>Review of the provider's undated Sanitizer Bucket Log revealed the director of dining services or assigned designee would monitor sanitizer log daily for accuracy and compliance.</p> <p>Review of the provider's undated Cleaning Exhaust Hoods revealed the hood exterior areas were to have been wiped with a solution of warm water and detergent daily.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p>	F 441	<p>F441</p> <p>1. All residents are at risk. Sanitary conditions are maintained during dressing changes for all residents. All staff perform proper hand hygiene while meals are being served. The facility does ensure that cleanable surfaces are maintained. The shower chair cushion has been replaced.</p> <p>2. The DNS will in-service all nurses on the policy and procedures related to infection prevention & control during dressing changes. Additional education will be provided to all staff on the appropriate hand hygiene during meal pass, as well as to report any findings of an item that has a uncleanable surface to a supervisor. In-service will be completed no later than March 13, 2015.</p> <p>3. The DNS or designee will perform random audits of dressing changes weekly x 4, then monthly x 3 to ensure that infection prevention and control is maintained during dressing changes. The</p>	3/31/15	

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F 441	<p>Continued From page 14</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on observation, interview, record review, and policy review, the provider failed to maintain: *Sanitary conditions during a dressing change by licensed practical nurse (LPN) G for one of one sampled resident (8). *Proper hand hygiene (cleaning) during one of two observed meals served. Findings include:</p> <p>1. Observation on 2/10/15 at 2:50 p.m. in resident 8's room with LPN G and certified nursing assistant (CNA) H revealed LPN G: *Laid two barriers (clean paper and or plastic sheet put down to prevent supplies touching unclean surface) down on the bedside table. The bedside table had not been cleaned off before barriers were laid on top of it. *Put on clean gloves. *Pulled a half full garbage bag out of the waste basket by the sink and set it on the bed sheet just below the resident's buttocks who was lying on her left side and was facing the wall. *Pulled a dressing off a pressure ulcer (red or</p>	F 441	<p>DNS or designee will complete random audits of staff hand hygiene during meal pass and ensure equipment is maintained with cleanable surfaces weekly x 4, then monthly x 3. Results of the audits will be reported by the DNS and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 31, 2015</p>	

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F 441	<p>Continued From page 15</p> <p>opened skin area) on the left buttock and the area of a tissue injury on the right buttock.</p> <p>*Used a plastic circular measuring tool on the right buttock injury where the skin was still closed. Then moved the tool to the left buttock pressure ulcer where skin was open touching both areas of the skin with the same plastic measuring tool.</p> <p>*Removed her gloves.</p> <p>*Washed her hands under running water for four seconds.</p> <p>*Picked up a pen and wrote the measurements of the pressure ulcer and the other skin injury on a paper towel.</p> <p>*Put on clean gloves without washing her hands again.</p> <p>*Picked up a new dressing and applied it to the pressure ulcer and the tissue injury areas without cleaning the wound first or using barrier spray as had been ordered by the physician on 2/4/15.</p> <p>*Gathered the used materials and placed them in the garbage bag on the bed, then removed the garbage bag from the bed linen.</p> <p>*Removed her used gloves and discarded them in the garbage.</p> <p>*Washed her hands under running water for seven seconds.</p> <p>Interview on 2/10/15 at 6:00 p.m. with the director of nurses (DON) revealed:</p> <p>*LPN G had gone to the DON and informed her she had not cleaned the wound during the dressing change.</p> <p>*The LPN had not informed the DON of any other missed steps during the observed dressing change.</p> <p>Continued interview at the above time with the DON after the multiple missed steps observed were shared with the DON revealed she agreed:</p>	F 441		

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F 441	<p>Continued From page 16</p> <ul style="list-style-type: none"> *The bedside table should have been cleaned off prior to the dressing change. *The garbage bag should not have been removed from the waste basket and placed on the bed linen next to the resident. *The measuring device should not have touched both the pressure ulcer area and the skin injury area. *Her hands should have been washed for twenty seconds before clean gloves were put on and after soiled gloves were removed. *Both skin areas should have been cleaned before the new dressing had been applied. <p>Review of resident 8's complete medical record revealed the following physician's orders:</p> <ul style="list-style-type: none"> *1/25/15 measure both the deep tissue injury on right buttock and the pressure ulcer area on the left buttock until healed. *1/25/15 clean suspected deep tissue injury to right buttock and apply barrier film spray every three days until healed. *1/27/15 change the Tagederm Hydrocolloid Thin dressing to the pressure ulcer on the left buttock every week until healed. <p>Review of the provider's undated Handwashing/Hand Hygiene policy revealed:</p> <ul style="list-style-type: none"> *Employees must wash their hands for at least twenty seconds using soap and water after contact with non-intact skin. *The use of gloves does not replace handwashing/hand hygiene. <p>Review of the provider's updated Types of Personal Protective Equipment: Gloves policy revealed:</p> <ul style="list-style-type: none"> *Disposable gloves were to be used when contact with non-intact skin was expected. 	F 441		

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F 441	<p>Continued From page 17</p> <p>*Handwashing was necessary even if gloves were worn.</p> <p>Review of the provider's 2006 Clean Dressing Change procedure revealed: *A plastic bag should have been placed near the foot of the bed to receive soiled dressing. *The wound should have been cleaned with the prescribed solution.</p> <p>Surveyor: 32335 2. Observation on 2/10/15 from 12:05 p.m. through 12:30 p.m. revealed five random certified nursing assistants (CNA) had been assisting with serving meal trays. During those observations those CNAs had not used hand sanitizer or washed their hands after serving trays and setting up the residents' meals.</p> <p>During a group interview on 2/10/15 at 2:00 p.m. the residents stated the CNAs did not use hand sanitizer when serving meals. They had seen them touch their hair and face during the meal services. That had bothered the residents.</p> <p>Surveyor: 33265 Interview with the director of nursing on 2/11/15 at 4:40 p.m. revealed she was surprised by what was observed. She stated they had just gone over hand hygiene training with the staff.</p> <p>Surveyor: 32331 B. Based on observation, interview, and policy review, the provider failed to ensure a cleanable</p>	F 441		

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F 441	<p>Continued From page 18</p> <p>surface in one of one shower chair cushion (west hall whirlpool and shower room). Findings include:</p> <p>1. Observation and interview on 2/9/15 at 5:40 p.m. with the maintenance supervisor in the whirlpool and shower room on the west hall revealed:</p> <ul style="list-style-type: none"> *A whirlpool tub on one side of the room and on the other side of the room there was a shower area with a shower chair. *An "Out of Order" sign was on the whirlpool tub. *He stated the whirlpool tub was going to be replaced. *In the shower area of that room there was a plastic cushion attached to the top of the shower chair's seat. *The above cushion had: <ul style="list-style-type: none"> -Cracks along the sides. -Brown, white, and tan spots on the sides. *He stated that cushion was no longer a cleanable surface and needed to have been replaced. <p>Interview on 2/10/15 at 2:40 p.m. with registered nurse (RN) D regarding the shower chair cushion on the west hall revealed it:</p> <ul style="list-style-type: none"> *Was cracked along the sides, and there was some discoloration. *Was no longer cleanable. *Needed to have been replaced. <p>Interview on 2/10/15 at 2:45 p.m. with certified nursing assistant E and with RN D regarding the shower chair on the west hall revealed:</p> <ul style="list-style-type: none"> *The majority of the residents received showers in the west hall whirlpool and shower room. *A few residents preferred a towel placed on the shower cushion seat as a personal preference. 	F 441			

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F 441	Continued From page 19 *Most residents sat directly on the shower cushion seat. Review of the provider's revised October 2009 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed resident-care equipment would have been cleaned.	F 441		

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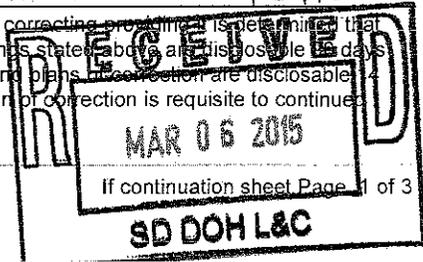
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501
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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/10/15. Golden LivingCenter-Pierre was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K011, K062, K67, and K068 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 3/11/15 telephone to facility administrator. CH/DOH/ME	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to ensure the automatic sprinkler system was maintained in accordance with the National Fire Protection Association (NFPA) 25. No corrective action had been taken regarding the sprinkler system 5-year report findings. Findings include: 1. Review of the provider's automatic sprinkler system required 5-year inspection report dated 3/19/14 revealed the following:	K 062	K062 1. All residents are at risk. The facility does ensure the automatic sprinkler system is maintained in accordance with the National Fire Protection Association. * [REDACTED] The 2/1/2 inch valve will be replaced and then backflow device will function properly. CH/DOH/ME 2. ED will in-service the Maintenance Supervisor to ensure all repairs are corrected after being identified from inspections. In-service will be completed no later than March 13, 2015. 3. The ED or designee will complete audits monthly X 4 to ensure all inspections have follow up completed	3/31/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jalli Rosta</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>3/5/15</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disposable 15 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 4 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 - PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501		
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K 062	<p>Continued From page 1</p> <p>*Item 32 (regarding the internal inspection): Found one 2-1/2 inch valve that will not shut. It needs to be replaced.</p> <p>*Item 33 (Explanation of "No" answer to Item 11 of the internal inspection): No. 2 check in the backflow (device) failed.</p> <p>*Item 35 (further explanation of Item 32): A 2-1/2 inch control valve for the 1997 addition needs to be replaced. It will not shut. Indicator shows it is shut, but water still runs by at a fast rate.</p> <p>Interview with the maintenance supervisor at 3:30 p.m. on 2/10/15 revealed he had been waiting for warmer weather in 2014 to have the repairs done to the sprinkler system.</p> <p>The deficiency had the potential to affect 100% of the building occupants.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, document review, and interview, the provider failed to maintain fire-resistive components for the ventilation ductwork in two randomly observed locations (the day room and the physical therapy addition). Findings include:</p>	K 062	<p>timely if repairs are needed. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. March 31, 2015</p> <p><i>* An outside vendor will be contracted to perform the required damper inspections. CH/SDDOH/MF</i></p> <p>K067</p> <p>1. All residents are at risk. The facility does maintain fire-resistive components for the ventilation ductwork in the day room and the physical therapy area.</p> <p><i>CH/SDDOH/MF</i></p> <p>2. The ED will in-service the Maintenance Supervisor to ensure that annual inspection of fire dampers with the fire alarm system is completed and repairs completed if needed. In-service will be completed no later than March 13, 2015.</p>	3/31/15

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

PRINTED: 02/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/10/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD 57501
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K 067	<p>Continued From page 2</p> <p>1. Observation at 2:00 p.m. on 2/10/15 revealed the day room had a plenum return air flow to a combination fire/smoke damper in the west wall of the mechanical room. The air movement was from the day room through open return grilles in the lay-in ceiling to the ducted damper in the west wall of the mechanical room.</p> <p>2. Observation at 2:15 p.m. on 2/10/15 revealed the two hour fire-rated wall between the day room and the physical therapy room had combination fire/smoke dampers installed in the ductwork.</p> <p>Document review at 2:30 p.m. on 2/10/15 revealed no record of annual operational testing of the dampers with the fire alarm system. Interview with the maintenance supervisor at the time of the observations confirmed that finding.</p> <p>The deficiency had the potential to affect 100% of the building occupants.</p>	K 067	<p>3. The ED or designee will audit monthly X 4 to ensure inspection is complete with follow up completed if there are areas of concern with the dampers. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits</p> <p>4. March 31, 2015</p>	
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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435047	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 2/10/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 011 NFPA 101 LIFE SAFETY CODE STANDARD

If the building has a common wall with a nonconforming building the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition Communicating openings occur only in corridors and are protected by approved selfclosing fire doors. 19.1.1.4.1, 19.1.1.4.2

This STANDARD is not met as evidenced by:
Surveyor: 18087
Based on observation and interview, the provider failed to maintain the fire-resistive characteristics of the two hour fire-resistive wall between the nursing home and the physical therapy building at the beauty shop (sprinkler pipe). Findings include:

1. Observation at 11:00 a.m. on 2/10/15 revealed an unsealed penetration opening above the lay-in ceiling in the two hour separation wall between the nursing home and the physical therapy building A two inch diameter sprinkler pipe in the wall between the beauty shop in the physical therapy building and the corridor in the nursing home was not sealed with an acceptable firestop material Interview with the maintenance supervisor at the time of the observation confirmed that finding

The deficiency affected one of numerous requirements to maintain fire-rated walls.

K 068 NFPA 101 LIFE SAFETY CODE STANDARD

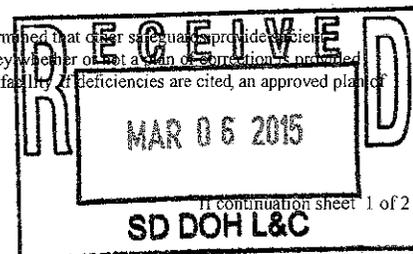
Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 19.5.2.2

This STANDARD is not met as evidenced by:
Surveyor: 18087
Based on observation and interview, the provider failed to install and maintain adequate combustion air for one of two locations required to be provided with dedicated combustion air supply for fuel-fired equipment (laundry room). Findings include:

1. Observation at 2:45 p.m. on 2/10/15 revealed two gas-fired dryers in the laundry room. The dryers had electrically controlled fresh air dampers installed in the ductwork above the dryers The damper control motors had been removed. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the dryer motors were new and had both failed The motors had been sent in

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 similar 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

The above isolated deficiencies pose no actual harm to the residents



STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435047	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 2/10/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 EAST PARK STREET PIERRE, SD
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
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K 068	<p>Continued From Page 1</p> <p>for repairs. He stated no instructions had been provided to laundry staff to open the exterior window in the room as a temporary fix for combustion air supply before operating the dryers</p> <p>The deficiency affected one of two locations required to be provided with dedicated combustion air supply for fuel-fired equipment.</p>
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ORIGINAL

PRINTED: 02/25/2015
FORM APPROVED

South Dakota Department of Health

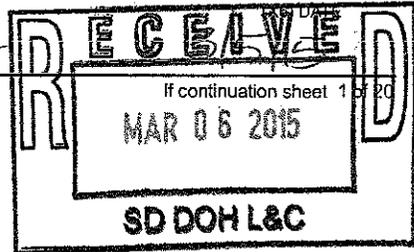
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE	STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/09/15 through 2/11/15. Golden LivingCenter - Pierre was found not in compliance with the following requirement: S166, S206, S236, S301, S355, S362, S465, S467, S468, S470, and S475.	S 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. 1. All residents are at risk. The Park Street exit door and the service wing exit door have activated audible alarms during the daytime hours. 2. The ED will in-service all staff to educate that the doors that are not visually	
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence	S 166		<p>Addendums noted with an asterisk per 3/11/15 telephone to facility administrator. CH/ROD/ME</p> <p>Addendums noted with two asterisks per 3/11/15 telephone to facility administrator. CH/ROD/ME</p> <p>S166</p> <p>3/31/15</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Dawn Rostice* TITLE: *Executive Director*



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501		
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S 166	<p>Continued From page 1</p> <p>when the door is closed;</p> <p>(7) Portable space heaters and portable halogen lamps may not be used in a facility;</p> <p>(8) Household-type electric blankets or heating pads may not be used in a facility;</p> <p>(9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and</p> <p>(10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to monitor two of three unattended exit doors (exit door opening onto Park Street from the commons area and the exit door in the service wing) without activated audible alarms during the daytime hours. Findings include:</p> <p>1. Observation on 2/10/15 at 7:45 a.m. and at 10:40 a.m. of the exit door opening onto Park Street from the main commons area revealed: *The door was not alarmed. *Residents were seated and walking in that area. *No staff were present in that area to observe who was entering or leaving.</p> <p>Observations on 2/10/15 at 11:20 a.m. and at 3:00 p.m. of the service wing exit door (near the boiler room) revealed: *The door was not alarmed.</p>	S 166	<p>monitored will be alarmed during the daytime hours, to include Park Street exit door and the service wing exit door. In-service will be completed no later than March 13, 2015.</p> <p>3. The ED or designee will complete audits weekly x 4 then monthly x 3 to ensure doors that are not monitored will have audible alarms that activate when opened. Results of the audits will be reported by the ED and discussed at monthly Quality Assurance and Process Improvement (QAPI) for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 31, 2015</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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S 166	<p>Continued From page 2</p> <p>*No staff were present in area to observe who was entering or leaving. *Residents would be able to walk down the hall and out the service wing exit without being seen.</p> <p>Interview on 2/10/15 at 11:20 a.m. with the maintenance supervisor revealed he thought enough employees were in the hall near the boiler room to monitor anyone coming and going out the exit door.</p> <p>Observation on 2/11/15 at 9:20 a.m. revealed the exit doors to Park Street from the main commons area and the service wing exit door were not alarmed and not within site of any staff.</p> <p>Interview on 2/11/15 at 4:40 p.m. with the director of nursing revealed: *She believed there was enough traffic through the commons area by the exit door to Park Street and the service wing exit door to not require an alarm during the daylight hours. *Those doors remained unalarmed longer as daylight increased during the spring and summer seasons.</p> <p>Review of the provider's 11/17/14 Door Security policy revealed: *The front door on Park Street and the service wing door alarms were turned off during the daylight hours. *Those two doors were then alarmed from 6:00 p.m. to 5:45 a.m. *The times of the doors alarming would vary according to seasonal conditions.</p> <p>Review of the provider's undated Door Locking policy revealed: *"It is the policy of Golden Living Center - Pierre to lock all of our doors at 11:00 p.m. at night and</p>	S 166		

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S 166	Continued From page 3 unlock them at 5:30 a.m. **"This is for the safety of our staff and residents."	S 166		
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review and interview, the provider failed to ensure all employees received training for two of ten mandated annual topics	S 206	S206 1. All residents are at risk. All employees receive an ongoing education program. An educational calendar has been developed to ensure all annual trainings are scheduled for the year. 2. The ED will in-service the Director of Clinical Education (DCE) on ensuring that all employees receive annual ongoing education to include: fire prevention and response, emergency procedures and preparedness, infection control and prevention, accident prevention and safety procedures, proper use of restraints, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting and the facilities reporting mechanisms, care of residents with unique needs, dining assistance, nutritional risks, and hydration needs. In-service will be completed no later than March 13, 2015. 3. The ED or designee will complete audits monthly x 4 to ensure that all employees have received education on a required subject per the educational calendar. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and	3/31/15

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S 206	Continued From page 4 (proper use of restraints; and dining assistance, nutritional risk, and hydration needs of residents). Findings include: 1. Review of the staff in-service records from January 2014 through 2/11/15 revealed there had been no staff training on proper use of restraints and dining assistance, nutritional risk, and hydration needs of residents. Interview on 2/11/15 at 3:00 p.m. with registered nurse D confirmed the in-service topics of proper use of restraints and dining assistance, nutritional risk, and hydration needs of residents had not been conducted for all employees within the annual time frame. Interview on 2/11/15 at 3:45 p.m. with the administrator regarding mandated annual inservice topics revealed the provider did not have a specific policy for that training.	S 206	recommendations and/or continuation/discontinuation of audits. 4. March 31, 2015	
S 236	44:04:04:08.01 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 Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare	S 236	S236 1. All residents are at risk. No corrective action could be taken for resident 15 as she has passed away. The facility does provide screening for tuberculosis within fourteen days of admission. 2. The DNS will in-service the DCE regarding the policy for TB screening. In-service will be completed no later than March 13, 2015 3. The DNS or designee will complete audits monthly X 4 to ensure that TB	3/31/15

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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S 236	<p>Continued From page 5</p> <p>worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on record review and requirements review, the provider failed to provide screening for tuberculosis within fourteen days of admission for one of fifteen sampled residents (15). Findings include:</p> <p>1. Review of resident 15's complete medical record revealed: *She was admitted on 12/31/13. *The tuberculin skin testing should have been completed by 1/14/14. *She had tuberculin skin tests done on 1/15/14 and 1/29/14.</p> <p>Interview on 2/11/15 at 4:40 p.m. with the director of nursing revealed she agreed the tuberculosis screening was not done within fourteen days of admission.</p> <p>Review of the provider's undated Tuberculin screening requirements revealed each new resident was to have received the two-step method of tuberculosis skin testing within fourteen days of admission to the facility.</p>	S 236	<p>screens for new admissions are completed timely. Results of the audits will be reported by the DNS and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 31, 2015</p>	
S 301	<p>44:04:07:16 Required dietary inervice training</p> <p>The dietary manager or the dietitian in ...nursing</p>	S 301		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2015
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S 301	<p>Continued From page 6</p> <p>facilities...shall provide ongoing inservice training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review and interview, the provider failed to ensure seven of nine required annual in-service training sessions (food safety, food handling and preparation techniques, food-borne illness, food serving and distribution procedures, leftover food handling policies, and time and temperature controls for food preparation and service, and nutrition and hydration) were offered yearly for all food handling staff. Findings include:</p> <p>1. Record review of the required in-service training sessions from January 2014 through 2/11/15 for all food handling staff revealed: *Those staff had received no annual training on the following: -Food safety. -Food handling and preparation techniques. -Food-borne illness. -Serving and distribution procedures. -Leftover food handling policies. -Time and temperature controls for food preparation and service. -Nutrition and hydration.</p>	S 301	<p>S301</p> <p>1. All residents are at risk. The DSM provides ongoing annual in-service training to all food handling staff. ^</p> <p>2. The ED will in-service the DSM and DCE regarding the requirement to provide annual education to all food handling staff to include the following: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distributing procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration and sanitation requirements . In-service will be completed no later than March 13, 2015.</p> <p>3. The ED or designee will complete audits monthly x 4 to ensure that the DSM or DCE has provided all food handling staff with the required annual education. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 31, 2015</p> <p><i>*An educational calendar was developed to ensure the annual trainings will be completed. KGS/DDH/ME</i></p>	3/31/15

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE			STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501		
(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 301	Continued From page 7 Interview on 2/10/15 at 3:30 p.m. with the dietary manager and on 2/11/15 at 8:20 a.m. with the director of nursing regarding required annual in-service training sessions for all food handlers revealed food handling staff were identified as dietary, nursing; and activities. Interview on 2/11/15 at 3:00 p.m. with registered nurse D regarding required annual in-service training sessions for all food handlers revealed: *There had not been an in-service on the above listed topics. *She had not known that all food handling staff were to have received that annual in-service training. Interview on 2/11/15 at 3:45 p.m. with the administrator regarding annual inservice topics for all food handlers revealed the provider did not have a specific policy on that issue.	S 301			
S 355	44:04:12:05 PROVISION OF SOCIAL SERVICES A nursing facility must provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee must be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility must have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly.	S 355	S355 1. All residents are at risk. The facility maintains a written contract and receives oversight from a licensed social worker for our social services coordinator. 2. The ED has developed a written agreement with a licensed social worker to provide consultation and assistance at least quarterly to our social services coordinator. Social services coordinator's first consult is on March 5, 2015. 3. The ED or designee will complete audits quarterly X 2 to ensure the social	3/31/15	

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S 355	<p>Continued From page 8</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on interview the provider failed to have a written contract and oversight from a licensed social worker for one of one social services coordinator. Findings include:</p> <p>1. Interview on 2/10/15 at 8:05 a.m. and again on 2/11/15 at 2:55 p.m. with the social services coordinator revealed she was not a licensed social worker. She had started working on 8/11/14 as the social services coordinator. She had graduated from a social work program in May 2014 but had not taken her test to become a licensed social worker. She had not had a licensed social worker consultant meet with her since she had started working in that position.</p> <p>Interview on 2/11/15 at 11:30 a.m. with the administrator revealed she did not have a written contract with a licensed social worker. She had not had a licensed social worker visit since the current social services coordinator had started in August 2014.</p>	S 355	<p>services coordinator has a consult visits. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 31, 2015</p>	
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S 362	<p>44:04:13:03 Service Area In Care Units</p> <p>Each care unit must contain a service area which includes the following, except when the service is not required for licensure category:</p> <p>(1) Nurses' station with convenient access to handwashing facilities; (2) Nurses' charting; (3) Doctors' charting; (4) Communications; (5) Storage for supplies and nurses' personal effects;</p>	S 362	<p>S362</p> <p>1. All residents are at risk. The facility does provide adequate bathing facilities for our residents. The facility does ensure ice is used from a self-dispensing ice machine to prevent contamination. The Alzheimer's Care Unit (ACU) no longer uses the refrigerator freezer ice maker.</p> <p>* [REDACTED]</p> <p>CH/SD/DH/MF</p>	3/31/15
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S 362	<p>Continued From page 9</p> <p>(6) Nurses' toilet room;</p> <p>(7) Nurses' office'</p> <p>(8) Clean workroom for the storage and assembly of supplies for nursing procedures which contains a work counter and sink;</p> <p>(9) Soiled workroom which contains a work counter with a two-compartment sink with drainboards on each side, handwashing facility, a waste receptacle, soiled linen receptacles, a clinical sink with an exposed water trap seal, siphon jet or blowout actions, and a bedpan flushing device;</p> <p>(10) Medicine room adjacent to the nurses' station with a sink, refrigerator, locked storage, and facilities for preparation and administration of medication;</p> <p>(11) Clean linen storage area in an enclosed storage space;</p> <p>(12) Nourishment station containing refrigerated storage, self-dispensing ice machine, and a sink for serving between-meal nourishments;</p> <p>(13) Equipment storage room on each...resident wing or floor for storage of...resident care equipment such as intravenous stands, inhalators, air mattresses, walkers, wheelchairs, and similar bulky equipment;</p> <p>(14) ...Resident bathing facilities containing one shower, bathtub or whirlpool for each 15 beds not individually served. Whirlpool units with lifts may serve 30 beds;</p> <p>(15) Janitor's closet for storage of housekeeping supplies and equipment which contains a floor receptor or service sink. The janitor's closet space and equipment may be incorporated into the soiled utility room;</p> <p>(16) Isolation facilities for the use of those prone to infections as well as those suffering from infections....The entry into the isolation room must be through an anteroom which is equipped</p>	S 362	<p>CH/DOOH/MF * Need to order appropriate parts to repair. ^</p> <p>2. The ED will in-service the Maintenance Director to ensure that all equipment is repaired timely and in good working condition and in-service the ACU staff to ensure they are educated to not use the ice from the refrigerator freezer in the ACU. In-services will be completed no later than March 13, 2015</p> <p>3. The ED or designee will complete audits weekly X 4, then monthly X 3 to ensure the whirlpool tub in the west wing bathing room is working properly and ensure that ice is not being used from the ACU refrigerator freezer for residents at anytime. Results of the audits will be reported by the ED and discussed at monthly QAPI for further review and recommendations and/or continuation/discontinuation of audits.</p> <p>4. March 31, 2015</p> <p>* The tub will be repaired when the replacement parts arrive. CH/DOOH/MF</p>	
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S 362	<p>Continued From page 10</p> <p>with handwashing, gowning space and supplies, and space to handle clean and soiled supplies for the room or rooms served. Toilet, bathing, and handwashing facilities must be available for the isolation room patient without entry into the anteroom or general corridor. A nursing unit is not required to maintain an isolation facility if such facilities are provided elsewhere in the institution; ... (18) Multipurpose rooms for staff... residents, and... residents' families for conferences, reports, education, training sessions, and consultation.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087</p> <p>Based on observation and interview, the provider failed to have adequate resident bathing facilities for the number of licensed beds (72). One of four bathing locations was in disrepair (tub in the west wing bathing room). Findings include:</p> <p>1. Observation at 1:30 p.m. on 2/10/15 revealed the tub in the west bathing room had a sign on it stating "out of service." The building had a total of three tubs and one shower (acute care unit tub, physical therapy tub, west wing bathing room tub, and west wing bathing room shower). The licensed number of resident beds for the facility was seventy-two. Resident bathing facilities containing one shower, or a bathtub, or whirlpool can account for each fifteen beds not individually served. Whirlpool units with lifts may serve thirty beds. The existing tubs did not meet the whirlpool tub with lift standard. The remaining in-service bathing facilities would account for only forty-five residents.</p> <p>Interview with the executive director and the maintenance supervisor at 3:30 p.m. on 2/10/15 revealed they were unaware of the resident</p>	S 362		
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S 362	<p>Continued From page 11</p> <p>bathing capacity standards. They stated the tub in the west wing bathing room had problems with the temperature control indicator and was not planned for repairs.</p> <p>Surveyor: 33488</p> <p>B. Based on observation and interview, the provider failed to ensure ice had been used from a self-dispensing ice machine used for resident drinking purposes located in the secured dementia unit preventing cross-contamination. Findings include:</p> <p>1. Observation on 2/10/15 at 11:30 a.m. in the secured dementia (disease that effects memory) unit dining room revealed: *The refrigerator/freezer door was unlocked and opened revealing an ice cube tray on the top shelf with a scoop lying below it on the bottom shelf. *Unidentified staff members had used the ice to fill the juice pitchers for residents drinking during the noon meal service.</p> <p>Interview on 2/11/15 at 9:40 a.m. with certified nursing assistant F regarding the secured dementia unit refrigerator/freezer revealed: *Staff and residents had used the ice found in the freezer for drinking purposes. *She stated "Residents like to go in there and get ice for their drinks when it is open." *She was unaware the provider should have a self-dispensing ice machine to prevent contamination.</p> <p>Interview on 2/11/15 at 2:00 p.m. with the director of nursing (DON) regarding ice for resident drinking purposes located in the secured dementia unit's refrigerator/freezer tray revealed: *She had been unaware staff were using ice from an ice tray with a scoop located inside the</p>	S 362		
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S 362	Continued From page 12 refrigerator's freezer. *She had expected staff were bringing ice from the self-dispensing machine in the main dining room back to the secured unit when used for resident drinking purposes. The DON was unsure if the provider had a policy regarding ice not used from a self-dispensing machine. No policy had been provided to the surveyor prior to the end of the survey.	S 362		
S 465	44:04:18:05 Nursing facility required to maintain records A nursing facility must maintain employment records that verify the qualifications of the nurse aides as outlined in section 44:04:18:02. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to: *Maintain any records for nursing assistant students going through the nurse aide training program for two of nine reviewed student files (J and K). *Complete training records of nursing assistant students for three of three nursing assistant students (L, M, and N) who had completed the program. Findings include: 1. Review of the nurse aide training program (NATP) documentation revealed: *Two nursing assistant students J and K were	S 465	S465 1. All residents are at risk. The facility will maintain records for nursing assistant students going through the nurse aide training program (NATP). 2. The ED & DNS have reviewed the administrative rule; Nursing facility is required to maintain records. The DNS or ED will in-service the NATP instructor after we receive approval from the SD Board of Nursing regarding the need to maintain and complete thorough records for nursing assistant students going through the nurse aide training program. The facility is working with the SD Board of Nursing to obtain our approved training program, program coordinator, and primary instructor. 3. In lieu of auditing at this time the facility will be working to obtain the approved training program and working to educate ourselves to ensure all the program requirements are followed. The	3/31/15

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S 465	Continued From page 13 engaged in the NATP. There was no documentation in their files identifying what parts of the program they had or had not completed. *Three nursing assistant students, L, M, and N, had completed the NATP but had not had all the sections of the training process signed off as completed. Interview on 2/11/15 at 1:00 p.m. with the administrator, the director of nursing, and surveyor 32335 revealed: *They had an approved instructor for the NATP but she had quit in February 2014. *They found student nurse aide training documentation was missing after review of files at that time. *They had not had an approved instructor since February 2014. *They had utilized another approved NATP and instructor. *They were aware their waiver to continue their approved NATP had expired on 1/9/15. Review of emails sent between the South Dakota Board of Nursing, the South Dakota Department of Health Office of Licensure and Certification, and the administrator between 8/8/14 and 1/6/15 revealed the administrator was aware their NATP approval had expired in July 2014. Policies on the NATP were requested but none were made available for review by the end of the survey.	S 465	NATP will be reviewed and discussed at monthly QAPI for further review and recommendations 4. March 31, 2015	
S 467	44:04:18:08 Notice of change in approved training program The entity offering an approved nurse aide	S 467	S467 1. All residents are at risk. The facility will notify the SD Dept of Health (DOH)	3/31/15

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S 467	<p>Continued From page 14</p> <p>training program must submit to the department, within 30 days after the change, any substantive changes made to the program during the two-year approval period. The department shall notify the entity of its approval within 90 days after receipt of the information.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to notify the South Dakota Department of Health (SD DOH) within the specified thirty days when the primary instructor for the nurse aide training program (NATP) quit in February 2014. Findings include:</p> <p>1. Review of the nurse aide training program (NATP) documentation revealed: *The SD DOH had not been notified the previous approved primary instructor for the NATP had left in February 2014. The email notification had not been sent until 9/5/14.</p> <p>Interview on 2/11/15 at 1:00 p.m. with the administrator, the director of nursing, and surveyor 32335 revealed: *They had an approved instructor for the NATP but she had quit in February 2014. *They had not had an approved instructor since February 2014. *They had utilized another approved NATP and instructor. *They were aware their waiver to continue their approved NATP had expired on 1/9/15.</p> <p>Review of emails sent between the South Dakota Board of Nursing, the South Dakota Department of Health Office of Licensure and Certification, and the administrator between 8/8/14 and 1/6/15</p>	S 467	<p>within 30 days of any changes made to the nurse aide training program.</p> <p>2. The ED reviewed the administrative rule; Notice of change in approved training program. We will keep in contact with the Board of Nursing as we are continuing to advance our knowledge and are educating and training our nurse aide instructor while awaiting approval. The facility is working with the SD Board of Nursing to obtain our approved training program, program coordinator, and primary instructor.</p> <p>3. In lieu of auditing at this time, we will notify the Dept of Health and Board of Nursing with any changes to the NATP within 30 days after any change. The NATP will be reviewed and discussed at monthly QAPI for further review and recommendations.</p> <p>4. March 31, 2015</p>	

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S 467	Continued From page 15 revealed the administrator was aware their NATP approval had expired in July 2014. Policies on the NATP were requested but none were made available for review by the end of the survey.	S 467		
S 468	44:04:18:10 Qualifications of program coordinator The program coordinator of a nurse aide training program must be a registered nurse. The program coordinator is responsible for the general supervision of the program. General supervision means providing guidance for the program and maintaining ultimate responsibility for the course. The program coordinator must have a minimum of two years of nursing experience, at least one year of which is in the provision of long-term care services. The director of nursing of a facility may serve simultaneously as the program coordinator but may not perform training while serving as the director of nursing. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to ensure the director of nursing (DON) who was listed as the nursing assistant training program (NATP) coordinator was not performing training of the nursing assistant students. Findings include: 1. Review of the nurse aide training program (NATP) documentation revealed the DON's initials were documented on training records as having observed the competency for nursing	S 468	S468 1. All residents are at risk. The facility will ensure that the DNS will not train any of the nursing assistant students. The facility will follow the guidelines for the qualifications of the program coordinator. 2. The ED & DNS have reviewed the state administrative rule in regards to the qualifications of the program coordinator for the NATP. The facility is working with the SD Board of Nursing to obtain our approved training program, program coordinator, and primary instructor. 3. In lieu of auditing at this point, we will submit a new application to the SD Board of Nursing to re-apply for NATP and will be continuing to move forward to re-start our program upon approval. The NATP will be reviewed and discussed at monthly QAPI for further review and recommendations. 4. March 31, 2015	3/31/15

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S 468	Continued From page 16 assistant students L and M. Interview on 2/11/15 at 1:00 p.m. with the administrator, DON, and surveyor 32335 revealed: *The DON had participated in the training of some of the nursing assistant students. *They had not been aware the DON could not be part of the training if she was the NATP coordinator. Policies on the NATP were requested but none were made available for review by the end of the survey.	S 468		
S 470	44:04:18:11 Qualifications of Primary Instructor The primary instructor of a nurse aide training program must be a licensed nurse. The primary instructor is the actual teacher of course material. The primary instructor must have a minimum of two years of nursing experience, at least one year of which is in the provision of long-term care services. The primary instructor must have completed a course of instruction in teaching adults or must have experience in teaching adults within the past five years. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to ensure the primary instructor for	S 470	S470 1. All residents are at risk. The facility will ensure that the primary instructor for the nursing assistant training program is the actual teacher of the course material. 2. The ED and DNS have reviewed the state administrative rule regarding qualifications of the primary instructor for the NATP. The facility is working with the SD Board of Nursing to obtain our approved training program, program coordinator, and primary instructor. Once the primary instructor is approved we will continue to advance her knowledge. In the meantime, we are developing a plan to work with another facility to see if our potential primary instructor could observe another approved instructor. We will keep a time-line of all the additional trainings that we are doing to advance our	3/31/15

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S 470	Continued From page 17 the nursing assistant training program was the actual teacher of the course material. Findings include: 1. Review of the nurse aide training program (NATP) documentation revealed: *Nursing assistant students L, M, N, O, and P had parts of their NATP training documented as completed by nursing personnel (licensed nurses and certified nursing assistants) instead of by an approved NATP instructor. -That included the five areas required to be taught, and they had demonstrated compliance before providing any care to a resident. * RN D was listed on the 12/23/14 Application for Re-Approval of the NATP as the planned Primary Instructor. She had documented observing competency skills for nursing assistant student N on 10/8/14. -She was not an approved NATP instructor on 10/8/14. Interview on 2/11/15 at 1:00 p.m. with the administrator, director of nursing, and surveyor 32335 revealed they were not aware all of the course material needed to be presented by an approved NATP instructor. Policies on the NATP were requested but none were made available for review by the end of the survey.	S 470	knowledge to meet the requirements of the training program. 3. In lieu of auditing at this point, we will submit a new application to the SD Board of Nursing to re-apply for NATP and will be continuing to move forward to re-start our program. The NATP will be reviewed and discussed at monthly QAPI for further review and recommendations. 4. March 31, 2015	
S 475	44:04:18:13 Supervision of Students Students in a nurse aide training program may not perform any services unless they have been trained and found to be proficient by the instructor. Students in a training program may	S 475	S475 1. All residents are at risk. The facility will ensure that the nursing assistant students in the nurse aide training	3/31/15

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S 475	<p>Continued From page 18</p> <p>perform services only under the supervision of a licensed nurse.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 33265 Based on record review and interview, the provider failed to ensure seven students (J, K, L, M, N, O, and P) in the nursing assistant training program had been: *Trained and found competent by the instructor before providing services to residents. *Providing service under the supervision of a licensed nurse. Findings include:</p> <p>1. Review of the nurse aide training program (NATP) documentation revealed: *Two nursing assistant students J and K were engaged in the NATP. There was no documentation in their files identifying what parts of the program they had or had not completed. *Nursing assistant students L, M, N, O, and P had parts of their NATP training documented as completed by nursing personnel (licensed nurses and certified nursing assistants) instead of by an approved NATP instructor. -That included the five areas required to be taught, and they had demonstrated compliance before providing any care to a resident. *Nursing assistant student O was scheduled with a certified nursing assistant for the sixteen hours of skill checks on 1/13/15 and 1/14/15 instead of with the required licensed nurse.</p> <p>Interview on 2/11/15 at 1:00 p.m. with the administrator, director of nursing, and surveyor 32335 revealed they were not aware that: *All of the course material needed to be presented by an approved instructor.</p>	S 475	<p>program are trained and found competent by the approved NATP Instructor before providing services to residents.</p> <p>2. The DNS will in-service the NATP instructor after approval from the SD Board of Nursing in regards to ensuring that all nursing assistant students in the nurse aide training program are trained and found competent by the instructor. The facility is working with the SD Board of Nursing to obtain our approved training program, program coordinator and primary instructor.</p> <p>3. In lieu of auditing at this point, we will re-train 1 of 3 new employees listed [REDACTED] as directed in the letter from DOH dated 2/26/15. The other 2 listed, do not work in our facility any longer. We will continue to train our current certified nursing assistants to maintain those educational pieces as well. The NATP will be reviewed and discussed at monthly QAPI for further review and recommendations.</p> <p>4. March 31, 2015</p> <p>* (student P) KEKDDH/ME</p>	
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10663	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/11/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - PIERRE		STREET ADDRESS, CITY, STATE, ZIP CODE 950 E PARK PIERRE, SD 57501		
(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 475	Continued From page 19 *The sixteen hours of skill checks needed to be completed with a licensed nurse directly supervising the nursing assistant student. Policies on the NATP were requested but none were made available for review by the end of the survey.	S 475		