

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	---	--	---

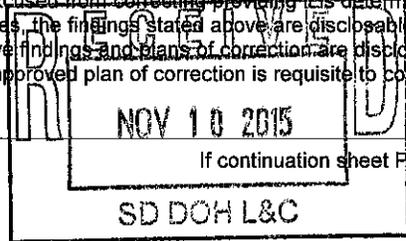
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><i>* Addendums noted with an asterisk per email per 11/12/15 with facility administrator.</i></p> <p>Surveyor: 32355 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/20/15 through 10/22/15. Golden LivingCenter - Redfield was found not in compliance with the following requirements: F166, F241, F309, and F356.</p>	F 000	<p>Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
F 166 SS=B	<p>483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 25107 Based on observation, testing, interview, and record review, the provider failed to ensure hot foods were served at high enough temperatures to be appetizing for residents on oral diets. Findings include:</p> <p>1. Review of the resident council meeting minutes from May 2015 to October 2015 revealed: *The old business minutes from May noted food temperature had been resolved to resident satisfaction. *In June dietary was discussed with no concerns identified. *The July new business minutes reported one resident had a concern food was not served at the correct temperatures during meals. *The August old business minutes stated dietary</p>	F 166	<p><i>*Cook to ensure air conditioning unit is off during serving times and will cover food when not continuously serving.</i></p> <p>F166 RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>1. Cook J was educated on 11/4/15 on the facility's Grievance Guideline to include the residents' right to prompt efforts by the facility to resolve grievances the resident may have. [REDACTED]</p> <p>2. All residents have the potential to be affected. All facility staff will be educated by 11/13/15 on the facility's Grievance Guideline to include the residents' right to prompt efforts by the facility to resolve grievances the resident may have. [REDACTED]</p> <p>3. The Social Services Designee or designee will randomly audit 5 grievances to ensure satisfaction of all parties involved and 5 residents to ensure hot foods are served at high enough temperatures to be appetizing weekly x 4 and monthly x 2. The Executive Director will report the results of these audits to the monthly QAPI committee for further review and recommendations.</p> <p><i>*and cook to audit food temperatures daily at each meal. Dietary service manager or designee will audit that a/c unit is off and food is covered.</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Diane Jorgy</i>	TITLE Executive Director	(X6) DATE 11-6-15
---	------------------------------------	-----------------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 166	<p>Continued From page 1</p> <p>food (not hot enough) was not resolved. The concern from last month had been resolved, but two new concerned residents had been identified. *The September old business minutes stated the food temperatures were noted as resolved. *In October it was noted nine residents agreed the food was "good" and no noted complaints. It was not documented if temperatures were discussed.</p> <p>Review of the resident council department response forms from the July and August 2015 meetings revealed the dietary manager was following up on resident satisfaction with residents who had expressed concerns.</p> <p>During the resident group interview on 10/20/15 at 4:00 p.m. with seven residents concerns were expressed hot foods were not served hot enough.</p> <p>Observation and testing on 10/20/15 at 6:20 p.m. revealed: *The tuna penne casserole was 125 degrees Fahrenheit (F) at the front of the pan where the casserole was shallow and in small quantity. The back of that same pan was 160 degrees F where the casserole was two inches deep. -The main dining room had been served, and the room trays were about to be served when the temperatures were tested. *The cook would scoop from the back of the pan most of the time but would occasionally serve from the front of the pan. *The casserole was in a large two inch cake pan and was not covered. *The air conditioner above the steam table was running and was blowing cold air down within feet of the steam table where the casserole was setting.</p>	F 166			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 166	<p>Continued From page 2</p> <p>Interview on 10/21/15 at 7:13 a.m. with a random resident who was eating breakfast in the dining room revealed her waffle was cold when it had been served to her.</p> <p>Observation and testing in the kitchen on 10/21/15 at 7:15 a.m. revealed: *The air conditioning unit above the steam table was running. *The waffles were in a large pan near the front of the steam table and were not covered. *The temperature of the waffles in the front of the pan was 98.0 degrees F.</p> <p>Interview on 10/21/15 at 7:20 a.m. with cook J revealed: *She was not aware the waffles had cooled to 98.0 degrees F. *She had tested them at the beginning of the meal service, and the temperatures were above 140 degrees F. *She had reheated the waffle for the resident interviewed above.</p> <p>Interview with cook J and the interim certified dietary manager on 10/21/15 at 11:22 a.m. revealed: *They were aware the residents had expressed concerns with the hot food over the last year. *They had focused on ensuring the temperatures were hot at the beginning of the meal service to ensure residents were served hot meals. *They had not tested throughout the meal service to ensure foods were staying hot. *They had not considered some food such as penne pasta and waffles would not hold heat as well as foods with a thick consistency. *They agreed the air conditioner running that</p>	F 166			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 166	Continued From page 3 close to the steam table would cool the foods quicker. Surveyor: 32335 Interview on 10/21/15 at 10:05 a.m. with resident 4 revealed the hot foods were not always served hot. That included room trays and meals served in the dining room. Surveyor: 22452 Interview on 10/21/15 at 3:30 p.m. with resident 8 revealed: *Her only concern was often her food at her meals was not hot enough. *It depended on who the staff member was if they would heat the food up when she asked. *She usually only went out to the dining room for breakfast. She ate her meals on a tray in her room for lunch and supper. *It was the trays that were brought to her room that were the problem. The food trays would sit out in the hall awhile before the tray was brought into her room.	F 166			
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, interview, and policy review, the provider failed to ensure privacy and dignity was maintained for one of six	F 241			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	<p>Continued From page 4</p> <p>sampled residents (3) during personal care by two of four certified nursing assistants (CNA) (B and C). Findings include:</p> <p>1. Review of resident 3's medical record revealed: *A 3/6/13 admission date. *Diagnoses of dementia (forgetfulness, memory loss), depression (sadness), aphasia (difficulty talking and expressing one-self), and anxiety. *She was dependent upon staff to assist her with all of her activities of daily living that included grooming, bathing, dressing, toileting, and moving from place-to-place.</p> <p>Observation on 10/20/15 at 4:30 p.m. of CNAs B and C with resident 3 revealed: *They had prepared to assist the resident with personal care in her room. *The resident was sitting in her recliner by a picture window. The window curtains attached to the window were open and faced the parking lot. That parking lot was used by visitors and was the loading area for the residents who traveled in the facility van. *CNAs B and C assisted the resident to stand using a stand-aide (mechanical lift used for transferring residents). *While the resident had been standing in the stand-aide the CNAs: -Pulled down her pants and incontinent brief (disposable undergarment). -Cleansed her perineal (private) area and pulled up her incontinent brief and pants. -Transferred the resident into her wheelchair. *CNAs B and C had not closed the window curtains during the resident's personal care. *The facility van had been parked outside of the resident's window. Staff had been observed</p>	F 241	<p>F241 DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>1. C.N.A.s B and C were educated on 11/3/15 on the facility's Dignity Policy to include promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Administrator, DON, and interdisciplinary team reviewed the Dignity Policy on 11/5/15, and team agrees no revisions to be made.</p> <p>2. All residents have the potential to be affected. All facility staff will be educated by 11/13/15 on the facility's Dignity Policy to include promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>3. The Director of Clinical Education or designee will randomly audit 5 resident personal cares for staff assisting residents in daily care in a dignified manner ensuring residents are not exposed weekly x 4 and monthly x 2. The Executive Director will report the results of these audits to the monthly QAPI committee for further review and recommendations.</p> <p>4. 11/13/15</p> <p>*to include resident #3 JK/SDDot/EL</p>	11/13/15 JK	

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 5 assisting an unidentified resident out of the van during the above procedure. Interview on 10/21/15 at 2:30 p.m. with the director of nursing confirmed CNAs B and C should have closed the window curtains. Resident 3 should have had her privacy ensured during any type of personal care. She agreed they had not assisted the resident with personal care in a private and dignified manner. Review of the provider's 2/26/15 Dignity policy revealed: **All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." **"Treating residents with dignity and respect maintains and enhances each resident's self-worth and improves his or her psychosocial well-being and quality of life." **Assisting residents in daily care in a dignified manner [ensuring residents are not exposed]."	F 241			
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 32355	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG F 309	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG F 309	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Continued From page 6</p> <p>A. Based on observation, interview, record review, and policy review, the provider failed to ensure effective pain management for:</p> <p>*One of one sampled resident (9) who voiced and exhibited signs and symptoms of pain during a dressing change by one of one licensed practical nurse (LPN) (A).</p> <p>*One of one sampled resident (1) who was cognitively [memory] impaired with communication deficits [problems] during personal care.</p> <p>Findings include:</p> <p>1. Observation on 10/20/15 from 3:10 p.m. through 3:30 p.m. with LPN A during a dressing change for resident 9 revealed:</p> <p>*The resident had been laying in bed on her back.</p> <p>*She had a dressing that covered her left ankle.</p> <p>*She was hard of hearing but able to understand the LPN's conversation and direction.</p> <p>*She became very anxious prior to and during any movement of her left foot and leg.</p> <p>*During the entire process of removing, cleansing, and re-dressing the wound the LPN had to move the resident's foot and leg.</p> <p>*During that entire time she grimaced and cried out "oh, oh, ow that hurts, what you doing now?"</p> <p>*The LPN had informed her of every movement and step she had to perform for her to complete the dressing change. Each time the resident would respond with the statements above.</p> <p>*The LPN had not asked the resident if she was having pain or offered to stop during the entire process of performing the dressing change.</p> <p>Interview on 10/20/15 at the time of the above observation with LPN A revealed:</p> <p>*The resident had received pain medication earlier that day. She stated "She receives</p>		<p>F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>A. 1. Nurse A and UAP I were educated on the facility's Pain Management Guideline on 10/22/15 and Nurse F was educated on 10/26/15. Pain Assessments were completed on Resident #1 and Resident #9 on 10/22/15. Pain assessments were completed on all residents by 11/3/15. Resident #9 and Resident #1's medication regime was reviewed and changes made. Resident #1's lift assessment was completed on 11/4/15, staff to utilize Sara lift and if resident #1 complains of pain, staff to stop and notify nurse and use the Maxi lift (total mechanical lift) at that time. Administrator, DON, and interdisciplinary team reviewed the Pain Management Guideline and Pain Scales including Pain Assessment in Advanced Dementia patients on 11/5/15, and team agrees no revisions to be made.</p> <p>2. All residents have the potential to be affected. All facility staff will be educated by 11/13/15 on the Pain Management Guideline and residents with cognitive impairment.</p> <p>3. The Director of Nursing Service or designee will randomly audit 5 resident dressing changes and 5 resident cares weekly x 4 and monthly x 2 to ensure effective pain management. The Director of Nursing Service will present the results of these audits to the monthly QAPI committee for further review and recommendations.</p> <p>4. 11/13/15</p>		<p>11/13/15 P8</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 7</p> <p>Tramadol (pain medication) every morning." *She had just given the resident a Gabapentin (nerve pain medication). She stated "She receives this three times a day." *She had not considered the resident's reaction to the dressing change as abnormal.</p> <p>Review of resident 9's complete medical record revealed: *A 7/1/15 re-admission date. *Diagnoses of dementia (forgetfulness), recent right lower leg amputation (removal) above the knee, history of shingles (painful blisters on the skin), unstageable (unable to determine severity due to condition of the open wound) pressure ulcer (broken skin over a bony area) to left ankle, and depression (sadness). *She was hard of hearing but was able to make her needs known. *She was dependent upon staff to assist her with all of her activities of daily living that included grooming, bathing, dressing, toileting, and moving from place-to-place. *She had been under hospice care (end-of-life) since May 2015.</p> <p>Review of resident 9's 10/20/15 physician's orders revealed the following pain medications: *Gabapentin 100 milligrams (mg) three times a day for shingles pain. *Tramadol 50 mg once a day for pain. *Tramadol 50 mg one tablet every six hours as needed (PRN) for pain.</p> <p>Review of resident 9's 10/1/15 through 10/20/15 medication administration records (MAR) revealed: *She had received the Tramadol at 7:30 a.m. every day.</p>	F 309	<p>B. 1. Resident #12's physician and psychiatrist were updated utilizing Behavioral Meeting Minutes, including any changes in behaviors on 11/4/15. Administrator, DON, and interdisciplinary team reviewed the Antipsychotic Medication Review Policy on 11/5/15, and team agrees no revisions to made.</p> <p>2. All residents have the potential to be affected. All facility staff will be educated by 11/13/15 on ensuring timely physician notification and involvement for changes in behavior for those residents on psychotropic medications.</p> <p>3. The Director of Nursing Service or designee will randomly audit 5 resident records weekly x 4 and monthly x 2 to ensure timely notification to the physician of change in behaviors weekly x 4 and monthly x 3. The Director of Nursing Services will report the results of these audits to the monthly QAPI committee for further review and recommendations.</p> <p>4. 11/13/15.</p> <p>*DNS or designee will review caretaker documentation daily to include resident behaviors. JK/SDDOHH/EL</p> <p>*Weekly behavior meetings will be held to include all residents receiving gradual dose reductions in anti-psychotic medications. JK/SDDOHH/EL</p> <p>*For those residents receiving gradual dose reductions in antipsychotic medications. JK/SDDOHH/EL</p>	11/13/15 JK

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 8</p> <p>*She had received the Gabapentin three times a day at 7:30 a.m., 1:30 p.m., and 8:00 p.m.</p> <p>*No other pain medications had been provided during that time frame.</p> <p>Review of resident 9's 9/7/15 Quality Care Meeting Summary revealed she had pain with the above pain medications ordered. No further changes had been required for her care plan.</p> <p>Review of resident 9's updated 10/12/15 care plan revealed:</p> <p>*There had been no problem area for pain.</p> <p>*Under the behavioral problem area there had been one intervention that stated "Make sure I am not in pain or uncomfortable."</p> <p>*Under the Hospice care problem area there had been one intervention that stated "Evaluate effectiveness of medications/interventions to address comfort."</p> <p>Review of resident 9's nurses' notes revealed:</p> <p>*On 8/21/15, "Hospice cares continue. Resident does say ou [ow] when anyone touches ankle and is to get scheduled Tramadol to help alleviate the pain and soreness."</p> <p>*On 8/22/15, "Area to left outer ankle treated per TAR [treatment administration record], drainage and redness noted to area. Resident does experience pain during treatment. Resolves after cares."</p> <p>*There was no documentation to support any PRN pain medications had been given or offered to the resident.</p> <p>*On 8/30/15, "Surrounding tissue is reddened with resident complaining of pain to the area. Area cleansed and treatment completed."</p> <p>*There was no documentation to support the resident had been given or offered pain</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 9</p> <p>medication prior to the dressing change.</p> <p>*On 9/3/15, "Resident had complaints of pain to ankle with dressing change."</p> <p>*There was no documentation to support the resident had been given or offered pain medication prior to the dressing change.</p> <p>*On 9/11/15, "Resident does wince when dressing change to ankle are done and pain medications given with relief obtained."</p> <p>*There was no documentation to support if the pain medication had been given prior to the dressing change.</p> <p>*On 9/14/15, "Resident noted to have pain with dressing changes to left ankle. PRN pain medication has been given and noted to be effective."</p> <p>*There was no documentation to support the pain medication had been given prior to the dressing change.</p> <p>*On 9/28/15, "Resident does wince when touching ankle and is on scheduled pain med and Gabapentin as ordered."</p> <p>*There was no documentation to support PRN pain medication had been given or offered for the resident's ankle pain.</p> <p>*On 9/30/15, "[physician's name] here to assess resident's plan of care/condition/medication for recertification with no new orders noted at this time."</p> <p>*On 10/20/15, there was no daily charting note available for review and to support the observation at 3:10 p.m. of the resident during the dressing change to her left ankle by LPN A.</p> <p>Interview on 10/21/15 at 3:15 p.m. with the Minimum Data Set (MDS) coordinator revealed:</p> <p>*The nurses had a pain management assessment form to have been used as a tool for them to determine a resident's pain level. They</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 10</p> <p>had completed that pain assessment with the residents' MDS assessments.</p> <p>*The nurses had been responsible for the follow-up with the physicians regarding pain management for the residents.</p> <p>*She would have only performed her required pain interview from the MDS section J. She would not have completed a pain assessment form to support her interview. She would have completed a nursing order for the charge nurses to review and follow-up on with any resident that had complaints of pain.</p> <p>*She had not been aware resident 9 had been experiencing pain during the dressing change. She had not visualized the wound or observed the dressing change. That had not been a part of her duties when completing an MDS assessment. She would have only interviewed the staff.</p> <p>Interview on 10/22/15 at 8:30 a.m. with the director of nursing regarding resident 9 revealed:</p> <p>*She supported the above interview with the MDS coordinator.</p> <p>*They had talked to the physician yesterday to increase her pain medications.</p> <p>*She agreed they had not visited with the physician regarding her pain and pain medications until after the surveyor brought it to their attention.</p> <p>*She would have reviewed the nurses' documentation on all of the resident's everyday.</p> <p>*She had not been aware of the resident's signs and symptoms of pain during the dressing change to her left ankle.</p> <p>*She would have expected the staff to give the resident pain medication prior to the dressing change.</p> <p>*She had been aware the Tramadol was scheduled once a day in the morning. If the</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 11</p> <p>nursing staff had not been able to do the dressing change until later that day she would have expected another pain pill to have been given. *She would have expected: -The nursing staff to stop the dressing change with complaints or signs and symptoms of pain. -The resident to have been provided a pain pill before resuming the dressing change.</p> <p>Surveyor: 22452 2. Review of resident 1's medical record revealed: *A 2/21/14 admission date. *Diagnoses: dementia (memory loss), anxiety disorder, major depressive disorder, osteoarthritis (pain in joints), and delusional (hearing things that are not real) disorders.</p> <p>Observation on 10/20/15 at 6:00 p.m. of resident 1 revealed she was hollering "help me" and trying to push her wheelchair backwards from the dining room table.</p> <p>Interview on 10/20/15 at that time with unlicensed assistive personnel (UAP) I regarding resident 1 revealed: *She often hollered out repetitively. *She had been hollering earlier in the day, and she had given her an as needed (PRN) Hydrocodone (narcotic pain medication). *The hydrocodone appeared to help the hollering for a little while until the effectiveness of the medication wore off.</p> <p>Observation on 10/21/15 from 9:00 a.m. to 9:30 a.m. of resident 1 revealed: *Certified nursing assistant (CNA) G was pushing her back to her room in her wheelchair after breakfast.</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 12</p> <p>*She was going to change her soiled sweater and provide incontinence care.</p> <p>*The resident was hollering "gotch ya" and "come on."</p> <p>*CNA G assisted her to stand in the mechanical stand-aide (equipment to move the resident that requires the resident to have the ability to bear weight on their legs).</p> <p>*When CNA G was positioning the resident's legs in the stand-aide she was hollering loudly and repetitively "ouch, ouch, ouch, hurts."</p> <p>*She was unable to tell CNA G where she was hurting.</p> <p>*She had facial grimacing when CNA G stood her from a sitting position in her wheelchair to a standing position in the stand-aide.</p> <p>*CNA G transferred her from that standing position to a sitting position on the toilet. She hollered "bad, bad, bad" in a loud tone of voice repetitively.</p> <p>*She rubbed her forehead and stated "head hurts" after CNA G assisted her back from the toilet to her wheelchair.</p> <p>*CNA G transferred her from her wheelchair to the easy chair in the day room with the use of the stand-aide.</p> <p>*The resident hollered "ouch, ouch, ouch" again in a loud tone of voice repetitively during that transfer.</p> <p>Interview on 10/21/15 at 9:40 a.m. with CNA G regarding resident 1 revealed:</p> <p>*The resident usually hollered frequently throughout the day. Some days the hollering was worse than others. It was hard to determine if she was having pain or if she was being repetitive.</p> <p>*She thought they had changed the resident's medications back in May 2015, and since then her hollering had increased. Prior to May the</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 13</p> <p>resident used to be able to carry on a conversation without yelling repetitively.</p> <p>*She thought the nurse had given her a pain pill at breakfast.</p> <p>*She was unsure what the medication was she used to be on, but she did not really holler at that time.</p> <p>*She often hollered "ouch" when they were providing personal care to her or transferring her with the use of the stand-aide.</p> <p>Interview on 10/21/15 at 10:00 a.m. with licensed practical nurse (LPN) F regarding resident 1 revealed she:</p> <p>*Had received her scheduled dose of Tylenol at breakfast.</p> <p>*Received scheduled Tylenol three times a day that had been ordered on 7/8/15. The use of the Tylenol had really made no difference in her hollering.</p> <p>*Had been on scheduled hydrocodone that seemed to make her memory worse and had made no change in her hollering. The hydrocodone had been changed to PRN on 7/8/15 when she was put on the scheduled Tylenol.</p> <p>*Had been put on a Fentanyl (narcotic pain) patch on 9/9/15. The patch had been stopped after two weeks, but she was unsure why.</p> <p>*Started hollering worse when her Risperdal (mood and behavior altering medication) had been discontinued on 9/9/15.</p> <p>*Often hollered out, but it was difficult to determine if that had been caused by pain.</p> <p>*Had not been hollering out about pain at breakfast.</p> <p>Review of resident 1's 5/8/15 through 10/20/15 nursing progress notes revealed:</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 14</p> <p>*5/8/15, "Brief interview for mental status [BIMS, testing of thought processes] and pain interview completed. Resident with nonsensical [does not make sense] answers. Long term memory/short term memory impaired, no memory recall, and daily decision making skills severely impaired. Noted to have inattention, disorganized thinking, and altered level of consciousness [alertness] which fluctuate."</p> <p>*5/11/15, "Pain scale for Tramadol/Tylenol at noon based on when resident is being transferred. No pain/discomfort noted when at rest. Resident was started on Tramadol one week ago."</p> <p>*5/12/15, "Resident has been having shakes off and on since Sunday afternoon. She was started on Tramadol 50 milligrams [mg] on 5/6/15 and also had a reduction in Risperdal from 0.5 mg to 0.25 mg on 5/4/15. She has not received the Risperdal for the last four to five days reported by the night nurse. Pharmacy has not sent a card but card is to be coming today."</p> <p>*5/13/15, "Seen by physician with orders to discontinue Risperdal, hold Tramadol, and discontinue Namenda [memory medication]. Continue to monitor pain/mental issues."</p> <p>*5/14/15, "Staff attempt to toilet resident and resident yelled ouch before staff got lift securely in place. Resident became agitated [angry] and pinched and attempted to scratch staff. Denies pain but yells ouch during transfer. Calmed down after finished in bathroom."</p> <p>*5/26/15, "Resident heard calling out and found laying on the floor beside her bed. Has history of multiple falls with and without injury."</p> <p>*6/4/15, "Monthly weight review indicates a loss of 9 pounds [lb]. Weight has been increasing from six months ago through May 2015 from 149 lb to 160 lb, and then she lost weight down to 151 lb. It</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 15 is noted that during her weight loss period her Namenda was discontinued for approximately two weeks. During this time, the staff noticed a decrease in her ability to feed herself and overall intake. It was restarted on 6/2/15. Her Risperdal was also discontinued." *6/10/15, "Seen by physician and order received for Hydrocodone 2.5/325 mg three times a day for arthritis pain." *7/2/15, "Weight is stable at 152 lb. Namenda was restarted and this is helpful for her to maintain her ability to feed herself." *7/8/15, "Seen by physician's assistant and order to discontinue Hydrocodone scheduled and PRN and start Tylenol 650 mg every a.m. and p.m." *7/12/15, "Resident has been calling out come on, come on for most of the shift. Nothing has made a difference in her calling out. Medications were changed last week." *7/15/15, "Was found sitting/lying in corner of the dayroom at approximately 6:40 a.m. Had been up since 4:30 a.m. and was placed in wheelchair since then. Was self propelling wheelchair around the unit/anxious/yelling." *7/20/15, "Has been having much more calling out since Hydrocodone was discontinued on Resident is either calling come on over or ow, ow over and over. Received order from physician for Hydrocodone 2.5/325 mg four times a day for twenty doses." *7/22/15, "Combative during clinical assessment. Had been sleeping in bed and found resident on mattress on floor next to bed." *7/31/15, "Has been calling out come on or help or ouch all shift. Does quiet down only for one-to-one visits." *8/13/15, "Has been yelling all day almost constantly ouch or come on and when questioned about pain points to different areas of the body	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 16</p> <p>every time."</p> <p>*8/14/15, "Seen by physician. Duragesic [Fentanyl] patch 12 micrograms [mcg] on every three days for thirty days."</p> <p>*8/20/15, "Orders for Gabapentin [chronic pain medication]. Physician' assistant telephoned and ordered Risperdal 0.5 mg at approximately 4:00 p.m. Targeted behaviors are increased disruptive sounds/excessive yelling out numerous times per day, wandering other residents' rooms and hallway, and very upset when calling out. Note resident received order on 7/8/15 to decrease alprazolam [antianxiety medication] from 0.25 mg in the a.m. and noon and 0.5 mg at bedtime to 0.5 mg at 4:00 p.m. From 5/22/15 to 7/7/15 resident had a total of twelve behaviors. From 7/8/15 to 7/27/15 after alprazolam was decreased resident had a total of twenty-five behaviors. Note behaviors continue to increase."</p> <p>*8/21/15, "Orders received to change alprazolam to 0.25 mg in the a.m. and 0.5 mg in the p.m. and to discontinue the Risperdal."</p> <p>*9/13/15, "Resident was very loud and calling out all shift yesterday. Unable to get to stop calling out."</p> <p>*10/1/15, "Has been loud and anxious today. Wandering around the unit in her wheelchair running into anything and anyone that is in her way. Just before lunch she had wandered into the day room and was being loud and pulling her hair. Attempted to redirect with food and one-to-one attention which was not effective."</p> <p>*10/2/15, "Bruise to top of left shoulder reported by staff. Has dementia and is frequently loud, aggressive, and wandering in her wheelchair. It is possible that another resident had struck her on the shoulder."</p> <p>*10/5/15, "Had been sitting in wheelchair at table, but was then found lying on floor in front of</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 17 wheelchair. Patient [resident] has behavior of yelling ouch frequently even when sitting still." *10/6/15, "Resident is having increased pain to left ankle, ankle edematous [swollen], and is starting to bruise. X-rays negative for fracture." *10/8/15, "Has been non-stop yelling/calling out this morning. Only time she stops is if someone is talking with her. Will mock [copy] what staff say to her and then just continue yelling out. Shows no signs/symptoms of pain when this yelling is going on and she will stop calling out the minute someone starts to talk with her." *10/9/15, "Prior to, during, and after breakfast resident was yelling ouch, ouch, ouch. She was unable to tell me where she was hurting. She would also yell out come on. PRN Hydrocodone was administered and was effective." *10/10/15, "Monthly weight review indicates a 4 lb weight loss in thirty days and 16 lb weight loss in six months. Her weight has been trending down." *10/12/15, "Upon review of resident's chart and behavior log noted to have an increase in yelling out, disruptive sounds, and agitation. Resident is toileted, provided activities, one-to-ones, and snack. However is not able to be redirected at times." *10/13/15, "Per pharmacy recommendation, doctor agreed to discontinue lexapro [antidepressant] and start Cymbalta [antidepressant] 30 mg to see if this will help with pain/anxiety." *10/14/15, "Seen on rounds by physician. Physician noted that resident has shown increased restlessness, ongoing and continuous yelling out, pulling of own hair, and scratching at own skin. New order is for Risperdal 0.5 mg for increased behaviors." *10/19/15, "Continually yells out help, or owee or whatever she hears over and over again which is	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 18</p> <p>very upsetting to the other residents and causes the other residents to have behaviors also." *10/20/15, "While attempting to redirect resident away from crowded area resident's right arm was caught between the wall and wheelchair."</p> <p>Review of resident 1's 5/3/15 through 10/1/15 weight summary revealed: *5/3/15, Weight (wt) 160 lb. *10/1/15, Wt. 143 lb.</p> <p>Review of resident 1's 10/1/15 through 10/20/15 PRN medication record revealed: *Hydrocodone was documented as administered ten times on seven different days. There was no PRN Hydrocodone administered on thirteen days. *Her FACES pain rating scale (0 no hurt, 2 hurts a little bit, 4 hurts a little more, 6 hurts even more, 8 hurts a whole lot, and 10 hurts worse) was rated from a 4 to a 9. *All the documented doses of hydrocodone administered were "effective."</p> <p>Review of resident 1's 5/6/15 through 10/20/15 physician's progress notes revealed: *5/6/15, "Apparently with the scheduled Ultram [Tramadol], pain behavior has been better." *6/10/15, "She has a PRN Hydrocodone. Previous attempt with Ultram had side effect. Previously scheduled Hydrocodone led to significant cognitive [thinking, reasoning, and memory] change. We will try Hydrocodone 2.5/325 mg one three times a day and keep the PRN. Complaints of knee pain, but no falls or trauma. She is able to verbalize just a few issues." *7/9/15, "When I listened to her lungs she would say ow. Listened to her chest she was saying ow and when I was listening to her chest and I</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 19</p> <p>touched her knee she was doing ow at the same time. We are going to put her on Tylenol and we will see how she does and see if this makes any difference. Discontinuing her Hydrocodone."</p> <p>*7/22/15, "Has had more verbalizations of pain, more pain behaviors. We are going to increase Hydrocodone to 5/325 mg three times a day."</p> <p>*8/5/15, "Still having some pain behaviors. Ultimate goal is to get a Fentanyl patch. Will increase the Hydrocodone to 7.5/325 mg three times a day. Will have pharmacy consult to convert that over to a Fentanyl patch."</p> <p>*8/14/15, "Severely demented elderly person who keeps saying ouch. It is unclear if this is a depressive issue or if she actually has pain Started her on some narcotics with minimal improvement. Start her on Duragesic [Fentanyl] patch 12 micrograms per hour."</p> <p>*8/26/15, "Complaints of pain have basically resolved."</p> <p>*9/3/15, "We put her on Risperdal last week at 0.5 mg and we have been giving it in the afternoon. When I went to see her today she was quieter. When I saw her last week she was going up and down the halls hollering the entire time so between the small dose of medication of the Risperdal and her pain medications she seems to be in much better control."</p> <p>*10/14/15, "Nurses state since going down on the Risperdal she has had more agitation, more violent behaviors. She is pulling her hair out. She is inconsolable [unable to calm]. She is actually quite delusional [irrational thinking]. I don't see that she is on Risperdal anymore per chart. Previous dose was we had put her on Risperdal 0.5 mg that was back about a month ago. We are going to go ahead and restart that."</p> <p>Review of resident 1's May 2015 through October</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20</p> <p>2015 behavior logs revealed:</p> <p>*May 2015, Eight occurrences of behavior (verbal behavior, wandering, and other behavior).</p> <p>*June 2015, Ten occurrences of behavior (wandering and other behavior).</p> <p>*July 2015, Thirty-one occurrences of behavior (verbal behavior, physical behavior, and other behavior).</p> <p>*August 2015, Sixty-four occurrences of behavior (wandering, physical behavior, and other behavior).</p> <p>*September 2015, Twenty-nine occurrences of behavior (wandering, verbal behavior, physical behavior, rejects care, and other behavior).</p> <p>*October 1 through October 21, 2015, Thirty occurrences of behavior (wandering, verbal behavior, physical behavior, rejects care, and other behavior).</p> <p>Review of resident 1's 8/7/15 care plan revealed:</p> <p>***Needs pain management and monitoring.</p> <p>***Will not experience a decline in function related to pain.</p> <p>***Patient [resident] will achieve acceptable pain level goal.</p> <p>***Will maintain adequate level of comfort as evidenced by no signs/symptoms of unrelieved pain or distress.</p> <p>***Evaluate need for routinely scheduled medications rather than PRN pain medication administration.</p> <p>***Evaluate need to provide medications prior to treatment or therapy.</p> <p>***Evaluate what makes the patient's pain worse.</p> <p>***Monitor for nonverbal symptoms of pain such as facial grimacing or guarding [protecting]. Resident does a behavior of yelling ouch or come on.</p> <p>Review of resident 1's October 2015 medication</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 21</p> <p>administration record revealed she:</p> <ul style="list-style-type: none"> *Was not on Risperdal or the Duragesic patch. *Had received PRN hydrocodone seven out of twenty days. *Was on scheduled Tylenol 650 mg twice a day with facial pain ratings of 0 to 9. <p>Interview on 10/21/15 at 10:15 a.m. with the Alzheimer's unit director regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *When she had medication changes this summer they noticed a change in her behavior. *They questioned whether she was having pain. *When she was on the scheduled hydrocodone she was sleeping a lot more. *She had been on the Duragesic patch until the end of September 2015. It was ordered for a thirty day time frame from the physician and was not followed-up on when the prescription ran out. *The pharmacist had told the nursing staff they might have been going a little fast with her medication reductions, but nothing had been done with her medications for a long time. *She agreed the nursing staff felt the resident was not comfortable most of the time. *They felt she was out of control most of the time. <p>Interview on 10/21/15 at 11:15 a.m. with the medical director regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *He was unsure why the Fentanyl patch had been stopped. The pharmacy or nursing staff had not called the physician's office for a renewal prescription. *They had been trying to figure out if her yelling behaviors of pain was her organic brain syndrome (dementia), anxiety, or pain. *They had been working on trying to taper down antipsychotic (mood and behavior altering) medications on her and some of the other 	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 22 residents since July 2015.</p> <p>*They should try a long lasting narcotic for her. He would restart the Fentanyl patch today.</p> <p>*They had just started her on Cymbalta (antidepressant) on 10/6/15 which had good pain properties.</p> <p>*He would go along that her behaviors during the above observations were pain related.</p> <p>Review of the provider's 2/10/15 Pain Management Guideline policy revealed:</p> <p>*"To provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life, in concert with the patient's/resident's plan of care and goals for pain management."</p> <p>*"Recognizing and reporting pain as a 5th vital sign."</p> <p>*"Intervening to treat pain before the pain becomes severe."</p> <p>*"Anticipating pain during activities that may be uncomfortable [dressing changes]."</p> <p>*"The nurse develops a plan of care for pain management, if indicated, including the use of non-pharmacological [medication] interventions."</p> <p>B. Based on observation, record review, interview, and policy review, the provider failed to monitor, assess, and report to the physician in a timely manner changes in behavior for one of six sampled residents (12) related to changes in her psychotropic medication. Findings include:</p> <p>1. Observation on 10/21/15 at 5:30 p.m. of resident 12 revealed she was:</p> <p>*Sitting quietly feeding herself at the supper table.</p> <p>*Pleasantly confused.</p> <p>*Did not show any mood or behavior concerns.</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 23 while eating.</p> <p>Review of resident 12's medical record revealed: *A 9/2/14 admission date. *Diagnoses: Dementia with behavioral disturbances, generalized anxiety disorder, chronic depressive personality disorder, and unspecified psychosis.</p> <p>Review of resident 12's 9/5/15 care plan revealed: **"Multiple medication use. History of hallucinations [see things that are not present to others] and delusions [hear things that are not present to others]." **"Provide medications as ordered by the physician and evaluate for effectiveness." **"Refer to psychologist/psychiatrist for medication and behavior interventions." **"I sometimes have mood and behaviors which include history of wandering in hallway and other residents' rooms which may intrude on the privacy of others." **"I may get upset with family when they come to visit as they are unable to care for me at home and my dementia diagnosis I may not understand." **"History of resident to resident. Verbal behaviors directed at others-cursed, threatened staff, screamed at staff/others." **"Hoarding behaviors and rejection of medications. Hit others." **"Thoughts that she be better off dead or of hurting herself in someway."</p> <p>Review of resident 12's 5/23/15 through 10/20/15 nursing progress notes revealed: *5/23/15, "It was reported by another resident that this resident had hit the other resident in the</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 24 restroom." *6/1/15, "Note since taper of Detrol [medication for not being able to control urine] resident noted to be more cheerful. Staff reports she has been laughing and visiting more with other residents." *6/8/15, "Noted to be hitting staff this morning, yelling at the recorder about her mother and her money. Shaking office door." *7/9/15, "Medications include Aricept [for memory] 10 mg daily, Citalopram [antidepressant] 30 mg daily, Trazadone [antidepressant] 25 mg at bedtime, and Risperdal 0.5 mg twice a day." *7/21/15, "Resident was found trying to assist roommate up. CNA entered room and attempted to redirect resident. Resident was aggressive with CNA, took CNA arm and twisted it. Resident left bruise on staff arm." *7/22/15, "Medications reviewed and order to continue taper of Risperdal and discontinue." *7/24/15, "Resident has been having increased outbursts just yelling out unknown reasons. Has also grabbed staffs' arms and twisted them. Psychiatrist was here and increased Risperdal to 1 mg twice a day. Risperdal was decreased from 0.5 mg twice a day to 0.5 mg on 7/8/15 and then discontinued on 7/22/15. Psychiatrist then gave order to start Risperdal 0.5 mg twice a day." *7/31/15, "Resident has had a few outbursts today. Yelled at staff and called another staff member names and then also backed staff into a corner and attempted to throw hot coffee on staff." *8/6/15, "Pharmacy recommendation related to citalapram [antidepressant] and depression. Noted orders from physician [primary, not psychiatrist] to discontinue citalapram and start Cymbalta [antidepressant] 30 mg daily." *8/13/15, "Became angry at other resident while they were sitting at the table and stated for them</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 25 to get out of her house." *8/16/15, "Resident continues to anger very easily and yells at staff and other residents when becomes upset. This has been happening more frequently since she has had medication changes." *8/19/15, "Resident noted to be crying this afternoon. Space and tissues provided as resident started to become agitated with staff." *8/23/15, "Resident agitated this morning. Telling staff and other residents that this is her home and everyone is supposed to get out. Attempted to hit another male resident. Male resident told her to stop and held up his hand so she did not hit him." *8/24/15, "Spoke with physician [primary] regarding increased agitation and suicidal ideation [ideas]. Note order to discontinue Cymbalta and see on rounds next week." *8/28/15, "Resident agitated and aggressive towards staff, hollering at staff and grabbing staffs' arms." *8/29/15, "Resident asked CNA to go outside after lunch. CNA said she would have to wait and resident became aggressive with CNA, grabbing her uniform and yelling she wanted to go outside." *9/2/15, "Orders from physician [primary] for Ativan [antianxiety] 0.5 cubic centimeters [cc] every two hours PRN." *9/7/15, "Became upset after supper towards tablemate and grabbed her shirt." *9/11/15, "Note order to increase Trazadone back to 50 mg every bedtime, restart citalopram 30 mg daily, and reduce Risperdal to 0.5 mg daily per physician [primary]." *9/18/15, "Facsimile [fax] received from physician [primary] stating we are to increase Trazadone to 75 mg and cut Risperdal in half and he would see her next week."</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 26</p> <p>*9/22/15, Resident has been having increased episodes of crying and picking at skin. Crying she wants to go home and picking at skin the whole time she talks about going home."</p> <p>*9/25/15, "Seen by psychiatrist and to continue on current medications."</p> <p>*9/28/15, "Fax received from primary physician agreeing with psychiatrist's recommendations of no changes in medications."</p> <p>*9/30/15, "Note order to discontinue Risperdal and increase Trazadone to 75 mg at bedtime for depression. [There was no documentation the psychiatrist had been notified of those medication changes]."</p> <p>*10/12/15, "Staff reported resident has diarrhea [loose bowel movement] this morning. Left the dining room table and went back to her room. Neighbor reported to staff that resident pulled another resident's hair. The other resident was neighbor, while the neighbor was sitting on the bed."</p> <p>*10/17/15, "Resident has been pacing and getting more and more agitated throughout the shift. When CNA went into resident's room to assist resident's roommate, she started screaming and hitting at the staff to get out. Had been awake the entire shift."</p> <p>Review of resident 12's 8/26/15 through 10/14/15 physician's (primary) progress notes revealed: *8/19/15, "She had recently some medication changes that staff is concerned with, plus she is also having some problems with ambulation [walking]. Psychiatrist put her on Risperdal 1 mg twice a day and increased her Celexa to 30 mg daily. Apparently there had been some behavioral issues and he had increased her medications and that was on 7/24/15. We are going to continue all those. Continue to follow-up with psychiatrist."</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD		STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 27</p> <p>*8/26/15, "Seen for follow-up concerning dementia, aggressive behaviors, and possibly pain issues. We had started her on some Cymbalta and she became suicidal and required suicide watch. She is now off the Cymbalta and the symptoms have resolved. She is now getting along well with the Risperdal."</p> <p>*9/2/15, "She is being more aggressive and hitting people. Just randomly gets anxious and strikes out. Physical aggression towards staff and others."</p> <p>*9/23/15, "Basically is seen for psychosis, irritability, and agitation. It is improved. Stable on current medications. Will continue current care. Citalopram 30 mg daily, Ativan 0.5 mg every two hours PRN, Risperdal 0.5 mg every day, and Trazadone 50 mg every day."</p> <p>*10/14/15, "Nurses note she is more aggressive physically and verbally. As far as the psych [psychiatric] issues, reviewed psychiatrist's notes of 9/28/15. At that time he recommended Risperdal 0.5 mg daily, Aricept at bedtime, and Celexa. I reviewed her current medications. I don't see that she is on the Risperdal. We are going to request they follow psychiatrist's orders as far as her antipsychotic."</p> <p>Review of the consultant pharmacist's September and October 2015 monthly medication reviews revealed:</p> <p>*9/9/15, "Was on Cymbalta and became very aggressive and suicidal so it was discontinued. Still on Risperdal 0.5 mg twice a day and still aggressive and agitated."</p> <p>*10/7/15, "Risperdal was decreased to 0.5 mg daily on 9/11/15. Celexa 30 mg daily started on 9/11/15. Trazadone increased to 50 mg at bedtime on 9/11/15 and then 75 mg on 9/30/15. Risperdal discontinued on 9/30/15. Patient</p>	F 309		

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 28 [resident] very good."</p> <p>Review of resident 12's May 2015 through October 2015 behavior logs revealed: *May 2015, Fifteen occurrences of behaviors (verbal behavior, wandering, and resisting care). *June 2015, Seventeen occurrences of behaviors (verbal behavior, physical behavior, wandering, and resisting care). *July 2015, Eighteen occurrences of behaviors (hoarding, verbal behavior, wandering, and resisting care). *August 2015, Thirty-nine occurrences of behaviors (wandering, verbal behavior, and physical behavior). *September 2015, Twenty-two occurrences of behaviors (wandering, verbal behavior, physical behavior, self-abusive acts, and disrobing in public). *October 2015 (1 through 21), Seventeen occurrences of behaviors (verbal behaviors, physical behaviors, and resisting care).</p> <p>Review of resident 12's October 2015 medication administration record revealed she: *Received Risperdal 0.5 mg daily started on 10/14/15. *Ativan 0.5 cc was given two times PRN on 10/17/15.</p> <p>Interview on 10/22/15 at 9:00 a.m. with the Alzheimer's unit director regarding resident 12 revealed: *She started back on the Risperdal 0.5 mg on 10/14/15. Her primary physician said to follow the psychiatrist's orders from 9/25/15. *The staff on the unit had expressed to her they "felt she was out of control." *Her behaviors consisted of crying,</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 29</p> <p>resident-to-resident altercations [fights], and throwing things.</p> <p>*She thought the psychiatrist had thought his orders of 9/25/15 were being followed. The nursing staff had not notified him the primary physician had discontinued her Risperdal on 9/30/15 and had restarted it on 10/14/15.</p> <p>*The resident had been sent to the emergency room in November 2014 due to severe behaviors. Her mirror in her room had to be removed as she kept seeing her sister who had been raped (sexually assaulted).</p> <p>Phone interview on 10/22/15 at 9:30 a.m. with the consultant pharmacist regarding psychoactive medications revealed she:</p> <p>*Came in monthly and sat down with the Alzheimer's unit director and the director of nursing. She also visited with various staff on the unit. They talked about all the residents on psychoactive medications.</p> <p>*Started at the facility in May 2015. When she started there were twenty-five residents on psychoactive medications, and now there are about eight residents on them.</p> <p>*Felt some residents had tolerated the reductions or discontinuation of medications without significant changes in their behaviors, while other residents behaviors had worsened.</p> <p>*Felt some of the staff on the Alzheimer's unit did not wait long enough after a residents' medications were changed and right away wanted to call the physician.</p> <p>*Usually worked with the medication changes with the medical director. She had not developed a rapport with the psychiatrist yet, but she wanted to.</p> <p>*Felt the staff needed to "buy into" what they were trying to do with the reduction in psychoactive</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 30 medications.</p> <p>*Felt the staff needed to focus on more one-to-one activities prior to wanting to put the residents back on the psychoactive medications.</p> <p>*Felt she might have gone a little fast with some of the residents' medication reductions and discontinuations, but usually was catching if there were changes in their behaviors by staff interviews and reading the residents' medical records when she was there.</p> <p>*Could maybe have done better with getting the Alzheimer's unit director more involved initially when she started making changes in some the residents' medications.</p> <p>*Might have been a little aggressive, but felt there were a lot of opportunities to improve the residents' quality of life without the use of psychoactive medications.</p> <p>*Felt about eighty percent of the residents she had suggested psychoactive medication changes on to the physicians on had benefited rom the changes.</p> <p>Review of the provider's 5/4/15 Antipsychotic Medication Review policy revealed: **Review to ensure that the pharmacy consultant has reviewed the medication program at least monthly and made recommendations for dose reductions, as appropriate." **Review to ensure the physician has reviewed the medication program at least quarterly and has documented the reason for continuance or change in the medication." **Review to ensure documentation of psychology or psychiatry consults in the medical record. These consults should contain documentation which supports the therapeutic [best] benefit for the antipsychotic medication without serious side effects."</p>	F 309			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 356 SS=D	<p>483.30(e) POSTED NURSE STAFFING INFORMATION</p> <p>The facility must post the following information on a daily basis:</p> <ul style="list-style-type: none"> o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, record review, and interview, the provider failed to ensure the twenty-four hour nursing staff information was</p>	F 356	<p>F356 POSTED NURSE STAFFING INFORMATION</p> <ol style="list-style-type: none"> 1. No immediate correction could be taken at this time for past non compliance. Twenty-four hour nursing staff information is posted and reflects the actual staffing. 2. All residents have the potential to be affected. All facility licensed nursing staff will be educated by 11/13/15 that the twenty-four hour nursing staff information is posted and reflects the actual staffing that was on duty to provide the basic care needs to all residents. 3. The Executive Director or designee will randomly audit 5 Nurse Staffing Information for completeness weekly x 4 and monthly x 2. The Executive Director will report the results of these audits to the monthly QAPI committee for further review and recommendations. 4. 11/13/15 	11/13/15 P8	

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 356	<p>Continued From page 32</p> <p>posted and reflected the actual staffing that was on duty to provide the basic care needs to all fifty-eight residents. Findings include:</p> <p>1. Random observations from 10/20/15 through 10/21/15 by the nurses station revealed: *There was a was clear plastic holder attached to the wall with the nursing staff sheet inside. *The information on the sheet revealed: -The nursing staff available for that day. -The information changed everyday.</p> <p>Review of the provider's nursing staff sheets from 5/22/15 through 10/19/15 revealed: *The total number and the actual hours worked for all licensed and unlicensed staff that were directly responsible for residents' care during the evening and night shifts had not been provided. *The following dates revealed no hours documented for the evening and night shift staff: -May: one time; 5/22/15. -June: three times; 6/5/15. -July: five times; 7/1/15, 7/2/15, 7/7/15, 7/8/15, and 7/9/15. -August: two times; 8/18/15 and 8/24/15. -September: one time; 9/18/15.</p> <p>Interview on 10/21/15 at 4:20 p.m. with the administrator revealed: *The nursing staff sheet had been: -What the provider used to inform the residents and visitors of their current staffing for that day. -Updated daily and with any staffing changes that occurred throughout the day. -Each shift had been responsible for posting the next shift staffing and any changes that occurred. *She had not been aware the above nursing staff sheets had not been fully completed. *She agreed the nursing staffing sheets had been</p>	F 356			

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

PRINTED: 11/03/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/22/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 356	Continued From page 33 incomplete. *The provider had no policy or procedure in place for the staff to follow for the completion of those sheets.	F 356			

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

ORIGINAL

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/20/15. Golden LivingCenter - Redfield (building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	* Addendums noted with an asterisk per 11/12/15 per telephone with facility administrator. LF/SDDO/H/EL K069 COOKING FACILITIES ARE PROTECTED IN ACCORDANCE WITH 9.2.3. 19.3.2.6 NFPA 96 1. The commercial kitchen hood system was tied to the building fire alarm on 11/6/15 and the exhaust system part was ordered on 11/5/15 and will be repaired when part arrives. The Maintenance Director was educated on the NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations on 11/5/15. 2. All residents have the potential to be affected. All staff will be educated by 11/13/15 on the NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. 3. The maintenance director or designee will audit the commercial kitchen hood system to ensure it is tied to the building fire alarm system and the exhaust system for proper functioning weekly x 4 and monthly x 2. The Maintenance Director will report the results of these audits to the monthly QAPI committee for further review and recommendations. 4. 11/13/15. 11/13/15	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on document review, observation, and interview, the provider failed to ensure the commercial kitchen hood was continuously maintained in reliable operating condition in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (system not tied to building fire alarm, exhaust system not functioning correctly). Findings include: 1. Document review at 9:30 a.m. on 10/20/15 revealed a commercial kitchen equipment inspection report dated 9/9/15. That report was prepared by Dakota Fire Equipment. The report revealed no indication if the commercial kitchen	K 069	The commercial kitchen hood fire alarm annunciator will be added to the bi-annual kitchen hood inspection checklist. LF/SDDO/H/EL	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Jorgy TITLE: Executive Director (X6) DATE: 11-6-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NOV 10 2015
If continuation sheet Page 1 of 2
SD DOH L&C

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/20/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	<p>Continued From page 1</p> <p>hood fire suppression system was connected to the building fire alarm signaling system. Review of the fire alarm inspection report dated April 6, 2015 prepared by Automatic Building Controls Inc. revealed a comment on that report the system was not into the building fire signaling system.</p> <p>Observation at 1:30 p.m. on 10/20/15 in the dietary kitchen revealed an Amerex wet chemical fire suppression system was installed for the commercial kitchen hood. That system was not provided with a supervisory sensor further indicating that fire suppression system was not tied to the buildings fire alarm signaling system.</p> <p>Interview with the maintenance director at the time of the above observation confirmed that condition.</p> <p>2. Observation at 1:30 p.m. on 10/20/15 of the commercial kitchen hood revealed the exhaust fan was running at the time of observation. That exhaust fan was providing a substantial amount of negative pressure in the kitchen hood such. It was pulling a baffle spacer up into the hood duct leaving an open space into the duct work. That created a fire safety issue as the grease laden vapors were capable of bypassing the grease baffles and enter directly into the kitchen duct through the open space where the baffle space was located.</p> <p>Interview with the maintenance director at the time of the observation confirmed that condition. He indicated he had recently installed a new exhaust fan for the commercial kitchen ventilation system.</p>	K 069		

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

ORIGINAL

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435054	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 10/20/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD			STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/20/15. Golden LivingCenter - Redfield (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Diane Jorgy *Executive Director* *11-6-15*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

NOV 10 2015

If continuation sheet Page 1 of 1
SD DOH LSC

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	---	--	--

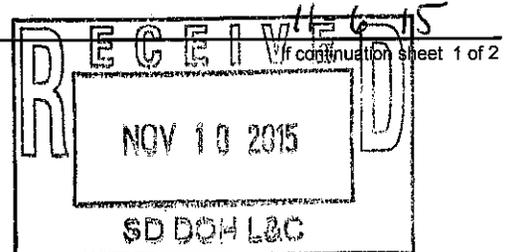
NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - REDFIELD

STREET ADDRESS, CITY, STATE, ZIP CODE
**1015 THIRD STREET EAST
REDFIELD, SD 57469**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Medical Facilities, requirements for nursing facilities, was conducted from 10/20/15 through 10/22/15. Golden LivingCenter - Redfield was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure exhaust ventilation was maintained in one randomly observed location (Advanced Alzheimer's Care Unit [AACU] dining area restroom). Findings Include: 1. Observation at 11:30 a.m. on 10/20/15 revealed a restroom in the AACU dining area. The restroom had a musty odor indicating exhaust ventilation might not be working correctly. Testing of the exhaust fan in that room confirmed it was not working. The exhaust fan would not turn on. Interview with the maintenance director at the time of the above observation confirmed that condition. He indicated that exhaust fan was on a preventative maintenance checklist to ensure it was functioning correctly. He was not sure why it	S 157	<p>*Addendums noted with an asterisk per 11/12/15 per telephone with facility administrator.</p> <p>S157 VENTILATION LF/SDDOH/EL</p> <ol style="list-style-type: none"> The exhaust ventilation fan was ordered on 11/5/15 and will be replaced when part arrives. The Maintenance Director was educated on ensuring that electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms and storage rooms on 11/5/15. All residents have the potential to be affected. All staff will be educated by 11/13/15 on ensuring that electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms and storage rooms. The Maintenance Director or designee will audit 5 exhaust fans for proper working order weekly x 4 and monthly x 2. The Maintenance Director will report the results of these audits to the monthly QAPI committee for further review and recommendations. 11/13/15 <p>*checking of exhaust fans will be added to our quarterly preventive maintenance check list. LF/SDDOH/EL</p>	11/13/15 AR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Diane Jorgay Executive Director

TITLE _____ (X6) DATE _____



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10671	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/22/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - REDFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 THIRD STREET EAST REDFIELD, SD 57469
---	---

(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 157	Continued From page 1 was not working at the time of the observation.	S 157		