

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

ORIGINAL

PRINTED: 09/24/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435049	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/10/2015
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 500 COLONIAL DRIVE SALEM, SD 57058		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/8/15 through 9/10/15. Golden LivingCenter - Salem was found not in compliance with the following requirements: F166, F226, F257, F280, F323, and F441.	F 000	*Addendums noted with an asterisk per 10/21/15 per telephone with facility administrator. The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted September 10 th , 2015. Please accept this plan of correction as the living center's credible allegation of compliance with the completion date of October 16 th . The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly resolve resident grievances in a timely manner for three of three random residents (1, 6, and 20). Findings include: 1. Review of an 8/16/15 grievance report regarding resident 6 revealed she had filed a complaint. The report stated "I don't want [staff name] that aide to take care of me. She is mean because she makes me wait to use the bathroom." The action plan was "This CNA [certified nursing assistant] was a temp [temporary] CNA. I spoke with her on Sunday and informed her of residents right to sit in recliner when asked. She then	F 166	RIGHT TO PROMPT EFFORTS TO RESOLVE COMPLAINTS 1. For Resident #6 ED met with resident who reports no further concerns and the temp in question has not been asked back. For Resident #20 there actually was a lengthy investigation completed including 10 grievances, all with		

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ronnica J Smith* TITLE *Executive Director* (X6) DATE *10/1/15*

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

OCT 08 2015

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F 166	<p>Continued From page 1</p> <p>transferred resident to recliner as asked." Under the nature of resolution section it stated "This temp CNA if returns to facility will be assigned a different wing." There had been no documentation of the resolution regarding the issue of making the resident wait to go to the bathroom. There was no further information on if the resident had complained of not sitting in the recliner. The documentation had been unclear.</p> <p>2. Review of an 8/25/15 grievance report regarding resident 20 revealed she had filed a complaint. The statement of concern was "Resident voiced that care staff was disruptive and disrespectful with her belongings when entering her room today and that she had a bad attitude."</p> <p>The action plan was "Will communicate with staff member and will communicate with DNS [director of nursing services]. Under the nature of resolution section it stated "I spoke 1 on 1 with CNA involved, she denied all of the allegations. She was instructed to avoid 1 on 1 contact." There had been no documentation an investigation had occurred regarding the grievance.</p> <p>3. Interview on 9/10/15 at 1:05 p.m. with the executive director and the social services coordinator (SSC) revealed there was no further documentation regarding the above grievances.</p> <p>Surveyor: 32332</p> <p>4a. Review of resident 1's medical record revealed a progress note on 8/21/15 at 1:36 p.m. from the social services coordinator (SSC)</p>	F 166	<p>follow up written on them, a call to and a visit from the Ombudsman. ED meets with resident multiple times per week to assess for concerns and further reports. Follow up is completed on each.</p> <p>For Resident #1</p> <div data-bbox="971 892 1416 1243" style="background-color: black; width: 100%; height: 100%;"></div> <p>There had been no further complaints filed until the end of August 2015 and those were being addressed. This corrective action was shown to surveys during their visit.</p> <p>Additional residents without full investigations are not able to be identified.</p>	
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SW/SD/EL

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F 166	<p>Continued From page 2</p> <p>indicating the resident had requested to visit with her. Resident 1: *Was crying in her room and stated she was having difficulty with a staff member (CNA B) at night. *Had requested a glass of ice water the evening before, and the CNA had told her she was busy. *Reported that had happened on other occasions. *Stated on 8/17/15 she had asked for a snack after her bible study. CNA B had refused to get her snack stating "you should have been in your room when I was handing them out." *Stated the CNA did bring her ice cream later in the evening.</p> <p>The SSC had documented resident 1 stated "This happens quite often with this staff member." The SSC had documented she had informed the DNS of the situation. She had filled out a grievance form and would continue to follow-up.</p> <p>b. Review of resident 1's medical record revealed a progress note on 8/27/15 at 9:11 a.m. from the SSC indicated resident 1 had requested to talk to her again. The resident had told her: *She did not want a certain CNA in her room as she did not like the care she received from that CNA. *That CNA was inappropriate toward her.</p> <p>The SSC had informed resident 1: *CNA B and the nursing staff would be reminded of her request. *She would continue to follow-up with the resident.</p> <p>Regarding the 8/21/15 grievance for resident 1: *The ED could not locate the 8/21/15 grievance in her files.</p>	F 166	<p>2. Interdisciplinary team reviewed the policy and procedure regarding investigations and re-education will be provided to all staff as to their responsibilities in the process of identifying, reporting and investigating resident accidents, injuries or complaints.</p> <p>[REDACTED]</p> <p>The re-education will include the completion of a verification of investigation form/process (when abuse or neglect indicated) that will document all areas reported during survey including:</p> <ol style="list-style-type: none"> The concern Resident response Assessment if appropriate Staff interviews Immediate intervention Long term intervention or corrective action if appropriate Resolution <p>*Education will be presented by the ED. SW/SDDOHT/EL</p>	<p>Employee conduct with residents / patients. SW/SDDOHT/EL</p> <p>* [REDACTED]</p> <p>will be provided 10/9/15 Cnd. SW/SDDOHT/EL</p> <p>thorough investigation process SW/SDDOHT/EL</p>

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F 166	<p>Continued From page 3</p> <p>*The SSC reported: -She had written the 8/21/15 grievance and given it to the DNS, but she was not sure what had happened after the DNS received it. -The DNS would have finished the investigation.</p> <p>Regarding the 8/27/15 grievance the SSC had written a grievance form indicating: *Resident 1 had reported the CNA she did not want in her room had been there twice on 8/26/15. *The action plan was to let nursing staff know and remind them the resident did not want that certain staff member in her room.</p> <p>There was no staff investigation documented on the grievance form regarding: *The care she had received from CNA B. *How CNA B had treated her inappropriately. *Interviews with other staff members working that night. *An interview with CNA B. *There was no resolution documented.</p> <p>c. At that same time the ED had another grievance form dated 8/29/15 and filled out by the ED. That form had indicated resident 1 had concerns that on 8/29/15: *CNA B would not give her snacks when she asked for them. *CNA B complained about other staff members.</p> <p>The action plan for that grievance had been: *"Assign that [CNA B] can not provide cares - communicated to the charge nurse." *The ED had documented she had explained to her: -She would not be able to guarantee CNA B would not come into the room to care for her</p>	F 166	<p>3. Each reporting period will review 10% or 10 grievances will be reviewed by the ED or designee to determine if a full investigation (as listed above) has been completed. The ED or designee will collect data one time a week four weeks and monthly times 2 months. ED or designee will report audit results monthly to QAPI for additional review and recommendations. The first report to QAPI will be 10/27/15</p> <p><i>*Results of audits will be brought to the monthly QAPI meetings for a period of 3 months or until committee feels no further monitoring is required. SW/SDDOH/EL</i></p>	10/16/15

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F 166	<p>Continued From page 4 room mate. - CNA B may have needed to enter the room if two staff members were needed to provide the care.</p> <p>There was no investigation documented. The ED had documented the grievance had resolved on 8/29/15.</p> <p>Further interview with the ED revealed: *She did not talk to CNA B about the grievance, because resident 1 had not wanted her to know where the grievance had come from. *She left a sticky note for the evening nurse on 8/29/15 indicating she was not to assign CNA B to resident 1. *She felt the grievances had been handled correctly. *She was not sure where the 8/21/15 grievance report was located. *CNA B had worked at the provider's facility for several years. *She had written up CNA B in January, 2015 regarding some resident mistreatment, but had not had any further mistreatment since then.</p> <p>d. Interview on 9/10/15 at 11:00 p.m. with the DNS revealed: *The SSC would have brought the grievances to the stand-up meeting. *Grievance reports were handed to the department responsible for the grievance. *She had remembered a grievance for resident 1 on her desk. *She had not recalled the grievance or what had been done for resident 1. *She had taken time off from 9/3/15 through 9/9/15.</p>	F 166			

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F 166	<p>Continued From page 5</p> <p>Interview on 9/10/15 at 2:00 p.m. with resident 1 revealed: *She had wanted the ED to talk to CNA B about the grievance. *She wanted to make sure CNA B knew she was not supposed to enter her room or assist with her cares.</p> <p>4. Interview on 9/10/15 at 9:00 a.m. with the ED and the SSC revealed: *The SSC had begun her position in July, so the ED was teaching her how to investigate grievances. *The SSC had documented the grievances in the progress notes, but she was not required to do so. *The SSC gave each grievance to the department head that would best fit the grievance problem. *The grievances had been discussed on the day following the grievances. *The department heads attended a "stand-up" meeting daily, and the grievances were discussed at the meetings. *The provider had five working days to follow-up on the grievance.</p> <p>Review of the provider's January, 2015 Reporting Alleged Abuse Violation policy revealed: *It was the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source, or misappropriation of resident property. *Staff, families and residents were encouraged to report incidents of suspected abuse, neglect, or misappropriation of resident property without fear of reprisal. *Reporting of suspected alleged violations was encouraged by all staff. *Incidents of alleged violations were reviewed by</p>	F 166			

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F 166	Continued From page 6 the provider's Quality Assurance and Performance Committee for detection of patterns and trends. *Any employee who suspected an alleged violation would immediately notify the executive director (ED) or a designee. *The ED would notify the state agency. *The results of all investigations were to have been reported to the ED or designee, and to the state agency within five working days. *The ED or DNS would conduct all investigations. If neither were working, the charge nurse was responsible for initiating the investigation procedure. *The investigation included interview of employees, visitors, or residents. *The medical record was to have been reviewed to determine the resident's past history and condition and its relevance to the alleged violation. *Federal law required the provider to have evidence of investigations of alleged violations. The Verification of Investigation form was completed after the investigation and was provided to survey agencies when requested. *The form was to have been maintained in the ED's office. *The provider was to make reasonable efforts to determine the cause of the alleged violation and take corrective action to eliminate any ongoing dangers to the resident. *Documentation in the medical record would be made where necessary for continuity of care for the resident. *Separate incident reports were to have been maintained in accordance with state law.	F 166			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226			

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F 226	<p>Continued From page 7</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate: *Resident complaints of staff neglect resulting in mental anguish for one of one sampled resident (8). *A fall for one of one random resident (14) who had a major injury. *A bruise of unknown origin for one of one sampled resident (6). Findings include:</p> <p>1. Review of resident 8's medical record revealed: *He had a care conference on 9/3/15 at 10:00 a.m. *During that meeting he informed staff that "certain staff" were not answering his call light at night. *The care conference checklist summary stated "Having trouble with the night aides 'I ain't going to do nothing' when he put his light on to use the bathroom. Continuously rude aide at night doesn't always answer the call light." *The care conference form had been signed by the social services coordinator (SSC), the activity coordinator and the dietary services manager.</p>	F 226	<p>DEVELOPMENT/IMPLEMENT ABUSE/NEGLECT, ETC POLICY</p> <p>1. For Resident #8 completed an investigation. [REDACTED] Interviewed 9 cognitive residents with no similar concerns about cited employee. There have been no similar concerns filed about this employee in the last year. When meeting with employee to review, discussed tone and how one might be perceived and instructed her not to provide services for a few days. The plan was to have her restart to see if resident could see a difference in performance however, employee will be transferring to day shift and facility will monitor for similar concerns and take appropriate action.</p> <p><i>SW/SD/SH/EL</i></p>	

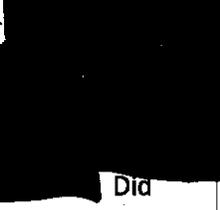
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F 226	<p>Continued From page 8</p> <p>Review of resident 8's 6/5/15 Minimum Data Set (MDS) assessment revealed he had a Brief Interview for Mental Status assessment score of 14 out of 15. He had no issues with his thinking ability.</p> <p>Interview on 9/8/15 at 5:00 p.m. with resident 8 revealed he:</p> <ul style="list-style-type: none"> *Had problems with one overnight staff person who would not help him. *Could not remember her name. *Used his call light when he had to use the bathroom. *Stated the above staff member would either not answer his call light or would enter his room, turn the call light off, and not assist him. *Was not supposed to go to the bathroom alone as his legs were weak. *Worried he might fall. *Stated sometimes she would put his wheelchair in the hallway, so he could not get to it. *Stated one night he waited an hour for his call light to be answered. -"I had to go so bad, it made me sick." *Reported his concerns to staff last week at his care meeting. *Did not know if they had done anything about it. *Stated "I hate to see her because I know I'm in for it" two different times during the interview. *Also stated "she caused me trouble" but had not stated what the trouble was. <p>Review of the grievance forms and incident reports revealed there was no documentation the above concerns had been addressed or investigated by staff.</p> <p>Interview on 9/10/15 at 1:05 p.m. with the executive director and SSC revealed:</p>	F 226	<p>For Resident #14 review had been completed but a full verification of investigation had not. Fall had occurred due to resident choosing to wash up on her own and slipping in the water. From facility standpoint, further investigation was not needed as staff were able to identify exact events and details and able to determine that abuse or neglect were not indicated..</p> <p>For Resident #6 -  Did  complete an investigation following survey and able to determine bruise was caused by resident hitting her leg with her fist. ^{completed} 9/11/15.</p> <p>Every resident in the facility could be at risk for lack of full investigation. No specific resident was identified at the time of plan of correction. As the investigative process is to</p>	
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F 226	<p>Continued From page 9</p> <p>*Resident 8 had informed the SSC about the issues with the overnight staff during his care conference on 9/3/15.</p> <p>*She had not passed on the information as she had "dropped the ball."</p> <p>*An investigation had not been completed.</p> <p>*Stated she spoke with the resident this week and he was doing okay.</p> <p>*She had not specifically asked him about the above staff person.</p> <p>*This surveyor had asked for any SSC notes pertaining to resident 8 but had not received any by the time the team exited the facility on 9/10/15.</p> <p>Review of the SSC Job Description signed on 7/13/15 revealed the SSC was responsible for "Identifying and providing for each resident's social, emotional and psychological needs, and the continuing development of the resident's full potential during his/her stay at the facility and to assist in the planning for his/her discharge."</p> <p>2. Review of a 9/4/15 initial and final investigation report sent to the South Dakota Department of Health regarding resident 14 revealed:</p> <p>*She had fallen 9/4/15.</p> <p>*It was an injury of an unknown source.</p> <p>*The following documentation was in the report: -The "Resident decided to wash herself up at the sink rather than have her shower, spilled water on the floor and fell. The resulted in a broken femur." -"Resident diagnoses include dementia [loss of mental function] with behavioral disturbances, schizophrenia [mental disorder characterized by abnormal social behavior and failure to recognize what is real], pain, edema, hepatic [liver] failure, functional dyspenia [indigestion], carcinoma [cancer] of the liver, gall bladder and bile duct." -"Resident is spending the night in the hospital to</p>	F 226	<p>identify if abuse occurred or not, or if change in cares would change the out come, facility would not take different action for Resident #6 or #15 once facility was able to determine no abuse or neglect.</p> <p>2.) For grievances, such as with Resident #8, the action plan would be the same as for F166. Re-education will be provided to all staff as to their responsibilities in the process of identifying, reporting and investigating resident accidents, injuries or complaints. Re-education will include the completion of a verification of investigation form/process that will document all areas reported during survey including:</p> <ol style="list-style-type: none"> The concern Resident response Assessment if appropriate Staff interviews Immediate intervention Long term intervention or corrective action if appropriate Resolution 		

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F 226	<p>Continued From page 10</p> <p>monitor pain control." -"This will be the initial and final report." *There had been no documentation regarding if the care plan had been followed, what the environment in the resident room had been, how they determined she had been washing herself at the sink, interviews with staff who had been working with her that day, or if she had been at risk for falls.</p> <p>Interview on 9/9/15 at 9:45 a.m. with the executive director (ED) and social services coordinator revealed there had been no further documentation regarding the above fall. They stated they had a meeting with the nurse consultant regarding investigations. She had stated they should be completing the Verification of Investigation (VOI) on each incident, but they had not been completing them. The ED could not provide the minutes of that meeting or the agenda for the upcoming staff meeting where she had planned on talking about the investigations. She could not provide the plan they would be implementing for completing the VOI. They had no other investigation information regarding the above situation.</p> <p>Surveyor: 32332</p> <p>3. Review of resident 6's medical record revealed: *On 9/4/15 at 9:37 p.m.: - RN G had documented a bruise to her upper left thigh measured 10 centimeters (cm) by sixteen cm. -At that time resident 6 stated she had not fallen and did not know what had happened to have</p>	F 226	<p>3.) Each reporting period will review 10% or 10 grievances will be reviewed by the ED or designee to determine if a full investigation (as listed above) has been completed. The ED or designee will collect data week times four weeks and monthly times 2 months. ED or designee will report audit results monthly to QAPI for additional review and recommendations. The first report to QAPI will be 10/27/15</p> <p>3.) Each reporting period will review grievances 10% or 10</p>	10/16/15

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F 226	<p>Continued From page 11 caused the bruise.</p> <p>*No further documentation regarding the bruise could be located in the staff progress notes or the treatment administration record.</p> <p>*The 4/20/15 Brief Interview of Mental Status (BIMS) (test to measure mental functioning) had been fourteen indicating her mental functioning had been intact (Okay).</p> <p>*The 7/2/15 BIMS score was fifteen, also indicated intact mental functioning.</p> <p>*The 8/26/15 Quality Care Meeting Summary had moderate depression with "causal factors" to have included cognition (mental functioning) problems.</p> <p>*A physician's consultation on 8/26/15 had indicated she had limited cognition, and her insight (understanding) was poor.</p> <p>*A 9/8/15 progress note by RN E. had indicated she had confusion and forgetfulness at times.</p> <p>Interview on 9/8/15 at 2:45 p.m. with registered nurse (RN) G revealed when asked if resident 6 was alert enough to be interviewed reported she was unsure, because she had periods of confusion.</p> <p>Interview on 9/10/15 at 11:15 a.m. with resident 6 revealed: *She was aware of the bruise. *She did not know what had caused the bruise. *"I didn't do anything. I didn't fall. I told everybody about it."</p> <p>Interview on 9/10/15 at 1:10 p.m. with the Minimum Data Set (MDS) coordinator and RN H (the nurse coordinator/case manager) revealed: *Neither of the nurses had known about the bruise. *If a resident was mentally alert the nurse would</p>	F 226		

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F 226	<p>Continued From page 12</p> <p>interview them to find out the cause of the bruise. *If the resident had been confused, the director of nursing services (DNS) would investigate it for a cause. *The DNS had been on a vacation during the period of 9/3/15 through 9/9/15. *They thought the nurse would have reported the bruise to the administrator in the DNS's absence. *The nursing staff would normally have continued to observe the bruise.</p> <p>On 9/10/15 at 1:30 p.m. RN G was unavailable for interview to discuss her 9/4/15 medical record entry and confirm or clarify a comment she had made during the initial survey tour on 9/8/15 about resident 6 experiencing periods of confusion.</p> <p>Interview on 9/10/15 at 1:55 p.m. with the executive director (ED) regarding resident 6 revealed: *She had not known about a bruise on the resident. *No investigation had been completed. *The resident had scored high on her BIMS, so an investigation would not necessarily have had to be done.</p> <p>Review of the provider's January 2015 Reporting Alleged Abuse Violation policy revealed: *It was the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source, or misappropriation of resident property. *Staff, families, and residents were encouraged to report incidents of suspected abuse, neglect, or misappropriation of resident property without fear of reprisal. *Reporting of suspected alleged violations was</p>	F 226			

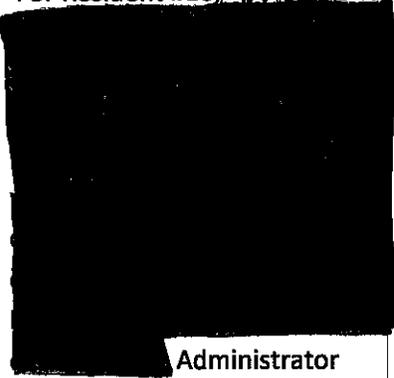
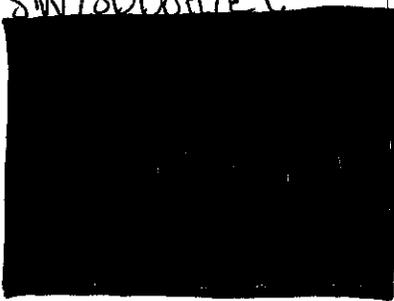
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F 226	<p>Continued From page 13 encouraged by all staff.</p> <p>*Incidents of alleged violations were reviewed by the provider's Quality Assurance and Performance Committee for detection of patterns and trends.</p> <p>*Any employee who suspected an alleged violation would immediately notify the executive director (ED) or a designee.</p> <p>*The ED would notify the state agency.</p> <p>*The results of all investigations were to have been reported to the ED or designee and to the state agency within five working days.</p> <p>*The ED or DNS would conduct all investigations. If neither were working the charge nurse was responsible for initiating the investigation procedure.</p> <p>*The investigation included interview of employees, visitors, or residents.</p> <p>*The medical record was to have been reviewed to determine the resident's past history and condition and its relevance to the alleged (claim to be true but not yet proven) violation.</p> <p>*Federal law required the provider to have evidence of investigations of alleged violations. The Verification of Investigation form was completed after the investigation and was provided to survey agencies when requested.</p> <p>*The form was to have been maintained in the ED's office.</p> <p>*The provider was to have made reasonable efforts to determine the cause of the alleged violation and take corrective action to eliminate any ongoing dangers to the resident.</p> <p>*Documentation in the medical record would be made where necessary for continuity of care for the resident.</p> <p>*Separate incident reports were to have been maintained in accordance with state law.</p>	F 226		

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<p>F 257 F 257 SS=E</p>	<p>Continued From page 14 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS</p> <p>The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, temperature testing, and interview, the provider failed to maintain temperatures in the dining room at a comfortable level for three of three randomly interviewed residents (16, 17, and 18) during three of three observations. Findings include:</p> <p>1. Interview on 9/8/15 at 5:50 p.m. with resident 16 revealed: *The resident had approached this surveyor and asked why they had to have it so cold in the dining room. *She had been sitting at one of the tables in the dining room closest to the entrance by the nurses station. *She wheeled herself out of the dining room to speak with this surveyor. *She stated she was so cold she had to keep her napkin up around her neck and over her chest. *During this conversation the administrator walked up to put residents' charts away. *She overheard the conversation and explained to the resident they had just cleaned the air conditioner vents. *She stated it would be colder in the center part of the building (dining room location) so the air would get pushed down to the rooms and the end</p>	<p>F 257 F 257</p>	<p>COMFORTABLE & SAFE TEMPERATURE LEVELS</p> <p>1.) For Resident #16, <i>SN/SDCOH/EL</i> *  Administrator completed a grievance report and follow up with included monitoring the thermostat in the dining room. When the thermostat was reading 70, Administrator contacted on-call maintenance for assistance and adjusted cooling system.</p> <p>* <i>SN/SDCOH/EL</i> </p>	

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F 257	<p>Continued From page 15 of the hallways.</p> <p>*The resident continued to state that it was cold.</p> <p>*The administrator stated "There is nothing we can do about it."</p> <p>Observation and temperature testing on 9/8/15 from 5:58 p.m. through 6:00 p.m. revealed it was 66.9 degrees Fahrenheit (F) in the dining room threshold by the nurses station. The temperature had been taken on a surveyor's calibrated thermometer.</p> <p>Interview on 9/9/15 at 8:10 a.m. with the activities director revealed they usually tried to have activities in the living room instead of the dining room. The dining room was too cold for the residents.</p> <p>Observation on 9/9/15 at 8:20 a.m. revealed an unidentified certified nursing assistant had removed resident 19 from the dining room. She stated to the resident "It's warmer out here," as she pushed the resident back to her room.</p> <p>Interview on 9/9/15 at 8:25 a.m. with resident 17 in the dining room revealed "It's freezing in here. It's always so cold. I put this [napkin] on my lap because it's cold."</p> <p>Observation on 9/9/15 at 8:26 a.m. revealed resident 18 was leaving the dining room. The resident stated to no one in particular "It is so cold in here."</p> <p>The temperature reading on 9/9/15 at 8:27 a.m. in the dining room by the first table was 63.7 degrees F. The temperature was taken on a surveyor's calibrated thermometer.</p>	F 257	<p>MAY not be able to do anything due to having a boiler system.</p> <p>* SW/SDD/A/EC</p> <p>SW/SDD/A/EC</p>	

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F 257	<p>Continued From page 16</p> <p>The temperature reading on 9/9/15 at 12:05 p.m. in the dining room by the first table was 65.1 degrees F. The temperature was taken on a surveyor's calibrated thermometer.</p> <p>Interview on 9/9/15 at 1:15 p.m. with a group of residents revealed they felt the dining room was cold. They had addressed the concern in resident council but could not remember the month it had been discussed. They felt the issue had not been resolved. The resident rooms were not cold, as they were not air conditioned. Most residents had fans in their rooms to circulate the air from the hallway.</p> <p>Review of the resident council minutes from April 2015 through September 2015 revealed during the 7/2/15 meeting under new business it stated "Reviewed policy on heating and cooling temperatures at the request of the ED [executive director]. Council had brief discussion." There had been no details provided regarding the discussion on if the residents thought the temperatures were okay or if they needed to be adjusted.</p> <p>Interview on 9/9/15 at 3:30 p.m. with the activities director revealed she was unable to recall if the residents had complained of the temperatures in the dining room being too cold. She repeatedly stated "I will have to read the minutes."</p> <p>Random observations from 9/8/15 through 9/10/15 revealed the resident rooms did not have air conditioners. Several of the resident rooms had fans to circulate the air. The rooms at the end of the 100, 200, and 300 halls were considerably warmer then the dining room. No temperatures were taken at the end of the</p>	F 257	<p>2.) Facility already does temperature checks in resident rooms at the beginning and end of the boiler loop on each hall and will add temperature check of the dining room to this daily check process.</p> <p>3.) Temperatures will be tested daily by the Maintenance Supervisor or Manager on Duty. The Maintenance Supervisor will report data to QAPI monthly for further review and recommendations. The first QAPI report will be made Tuesday, October 27, 2015.</p>	10/16/15	

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F 257	Continued From page 17 hallways as it was not as cold in those areas. Interview on 9/10/15 at 10:15 a.m. with the executive director and the interim maintenance supervisor revealed: *The maintenance supervisor had resigned his position at the end of August 2015. *The interim maintenance supervisor came from another facility where he worked full time. *They had just had the air conditioner vents cleaned. *The dining room was in the center of the building and it was cooler then the other parts of the building. *The air from the center of the building pushed out to cool the ends of the hallway. *They had increased the temperature yesterday afternoon and now have staff complaining that it was hot. *This surveyor shared the room temperatures mentioned above. *The administrator stated the thermostat had registered 70 degrees F which kept the temperatures "in range." *She repeatedly stated "They were in range." *The thermostat was outside of the dining room across from the nurses station. *She had agreed the temperatures in the dining room should have been based off of resident comfort.	F 257		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		

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	<p>Continued From page 18</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, record review, interview, and policy review, the provider failed to ensure one of one sampled resident (3) who had a current pressure ulcer (injury to skin usually from pressure and frequently over a bony area) had her care plan reviewed and revised to reflect the current status and most recent interventions in place to assist with healing. Findings include:</p> <p>1. Observation on 9/10/15 at 10:40 a.m. with registered nurse (RN) E regarding resident 3's pressure ulcer revealed: *There was a stage two (open area or outer layer of skin missing) pressure ulcer to the side of her left foot. *It was cleansed, wound gel applied, and a new dressing was placed over the pressure ulcer.</p> <p>Review of resident 3's medical record revealed:</p>		<p>RIGHT TO PARTICIPATE IN CAREPLANNING</p> <p>1.) Added pressure sore to Resident #3's careplan. <i>*and appropriate cares being done. SW/SDDOHT/EL</i></p> <p><i>*SW/SDDOHT/EL</i></p> <p>2.) Re-education will be provided to nursing and interdisciplinary team staff regarding updating care plans on a con-current basis. <i>*on 10/16/15</i></p> <p>3.) DNS or designee will review careplans of residents with falls, pressure areas and change of condition to ensure that care plans are updated as needed. Review will be completed for all residents with above x 4 weeks and then monthly x 3. DNS or designee will report results to QAPI on a monthly basis for additional review and assessment. The first report will be October 27, 2015.</p> <p><i>* results of audits will be brought to the monthly QAPI meetings for 4 months or until the committee feels no further monitoring is required. SW/SDDOHT/EL</i></p>	<p><i>by the DNS SW/SDDOHT/EL</i></p> <p><i>10/16/15</i></p>

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F 280	<p>Continued From page 19</p> <p>*She was admitted on 3/15/13.</p> <p>*Her diagnoses had included:</p> <ul style="list-style-type: none"> -Depressive disorder (a feeling of sadness that persists over a period of time). -Hyperlipidemia (high cholesterol). -Type II Diabetes Mellitus (too much sugar in the blood stream). -Pain. -Constipation (inability to have a bowel movement). -Cerebrovascular disease (a disorder regarding circulation and affecting the brain). -Anxiety. -Dementia (difficulty with thought process). <p>*On 4/18/15 a stage two pressure ulcer was identified on the left side of the foot measuring 3 centimeters (cm) by 2 cm. The treatments to the left foot ulcer were as follows:</p> <ul style="list-style-type: none"> *4/18/15 Tegaderm hydrocolloid dressing (a special dressing to promote wound healing) to be changed every three days. *4/27/15 Antibiotic started due to infection of the wound. *6/11/15 A wound vacume (vac; device for draining a wound) was applied to the ulcer. *7/14/15 Physical therapy (PT) was to evaluate and treat the wound. *8/18/15 Wound vac was discontinued and ulcer covered with a dressing. *9/1/15 Apply wound gel daily and apply tegaderm dressing. <p>Review of resident 3's 4/6/15 Minimum Data Set (MDS) significant change assessment revealed she was at risk for developing pressure ulcers.</p> <p>Review of resident 3's 7/7/15 MDS quarterly assessment revealed:</p> <ul style="list-style-type: none"> *She was at risk for developing pressure ulcers. 	F 280			

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F 280	<p>Continued From page 20</p> <p>*There was one unhealed stage three pressure ulcer.</p> <p>*She required the assistance of two staff to transfer and did not ambulate (walk).</p> <p>Review of resident 3's 4/17/15 comprehensive care plan revealed:</p> <p>*A weekly skin inspection was to be done by the nurse.</p> <p>*A handwritten update on 7/14/15 "Being seen by PT [physical therapy] for wound."</p> <p>*No additional updates were provided regarding the resident having an active pressure ulcer nor interventions that were being provided.</p> <p>Interview on 9/9/15 at 11:20 a.m. with the MDS nurse revealed:</p> <p>*She was responsible for initiating the care plan.</p> <p>*A care plan should have been reviewed and revised as the resident's condition changed prior to the next target date that coincided with an MDS quarterly assessment.</p> <p>*No explanation was given regarding a care plan update for the active pressure ulcer to her left foot.</p> <p>Interview on 9/10/15 at 11:00 a.m. with CNA A and CNA F revealed:</p> <p>*Staff were given information regarding skin issues in daily stand-up report.</p> <p>*No care plan was referenced for issues regarding resident 3's skin.</p> <p>Review of the provider's 2/24/15 Person Centered Care Planning policy revealed:</p> <p>*"The interventions are how the staff can help the resident reach their goals."</p> <p>*"The interdisciplinary care plan guides the living center's employee in the provision of necessary</p>	F 280		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - SALEM			STREET ADDRESS, CITY, STATE, ZIP CODE 500 COLONIAL DRIVE SALEM, SD 57058		
(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 280	Continued From page 21 care and services to attain or maintain the interests and the highest practicable physical, mental, and psychosocial well being of the resident based on the residents wishes."	F 280	FREE OF ACCIDENT HAZARDS 1.) Bottle currently in use was labeled while surveyors still present in the building. 2.) A proper disinfectant bottle with manufacturer's label was ordered. 3.) Maintenance supervisor or manager on call will check the whirlpool weekly x4 and then monthly x3 that the proper disinfectant bottle and label are being used. Maintenance Supervisor or designee will report to QAPI monthly. The first report will be given Oct. 27 th .	10/16/15	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation and interview, the provider failed to properly label as a disinfectant a bottle of solution used for one of one whirlpool tub. Findings include: 1. Observation on 9/9/15 at 9:00 a.m. with bath aide/certified nursing assistant (CNA) A. during a whirlpool tub cleaning revealed she pushed a button on the whirlpool tub to distribute a mixture of water and disinfectant onto the floor of the tub. Observation at that time of the area below the whirlpool housing the disinfectant bottle connected to the automatic button revealed a jug of solution labeled Classic Shampoo and Body Wash. Interview at that time with bath aide A revealed she stated:	F 323			

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F 323	<p>Continued From page 22</p> <p>*The liquid in the container was not for shampooing the residents.</p> <p>*That container had the disinfectant solution to clean the whirlpool tub.</p> <p>*The bathing assistants filled that container with disinfectant to use for cleaning the tub.</p> <p>*She had a large (liter) container of the Classic Disinfectant cleaner that she used to:</p> <ul style="list-style-type: none"> - Apply disinfectant to the scrub brush for cleaning the chair and sides of the whirlpool. - Refill the bottle of Classic Shampoo and Body Wash for disinfecting the whirlpool tub. <p>*She agreed it could pose a hazard if it had been used on the residents for bathing.</p> <p>Review of the provider's undated Disinfecting the Tub/Chair directions attached to the wall of the tub room revealed "REFILL Disinfectant and Bath Oil container under tub and prime as needed."</p> <p>Interview on 9/10/15 at 11:00 a.m. with the interim director of nursing services and the nurse consultant revealed they:</p> <ul style="list-style-type: none"> *Had not known about the disinfectant stored in the shampoo bottle until the bath aide brought it to their attention on 9/9/15. *Would not expect staff to use a shampoo bottle to store disinfectant. 	F 323		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program</p>	F 441		

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F 441	<p>Continued From page 23</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to: *Have an active infection control program to track and trend infections, conduct data analysis (organize the infection information into useful information), and determine the effectiveness of</p>	F 441	<p>INFECTION CONTROL, PREVENT SPREAD</p> <p>1.) A. Director of Nursing printed off Infection control policies and * [redacted] immediately. Initial report to QAPI was 9/27/15.</p> <p>*Re-educated staff D on aseptic technique *DCEL (director of clinical education) provided to nurse and staff aide staff. SW/SDDOT/EL</p> <p>[redacted]</p> <p>B ← * [redacted] housekeeping staff attended to fans while survey team was still in the building.</p>	

implemented SW/SDDOT/EL

13/HANDS/INS*

B ← * SW/SDDOT/EL

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F 441	Continued From page 24 infection prevention and control practices. *Ensure Foley catheter (tube inserted into the bladder to drain urine) care for one of two sampled residents (1) had been completed in a sanitary manner. *Ensure one of one observed bath aide (A) knew the proper technique for cleaning a whirlpool bath tub after bathing someone with clostridium difficile (C-diff) (a spore bacteria that causes infectious diarrhea). *Maintain fan cleanliness for: -Five of six hallway fans (Two in the 100 hallway, two in the 200 hallway, and one in the 300 hallway). -Two of four sampled residents with fans in their rooms (8 and 11). Findings include: 1. Interview on 9/10/15 at 11:00 a.m. with the director of nursing services (DNS) and the nurse consultant regarding the infection control program revealed: *The previous DNS had left the position approximately one month ago. *While the previous DNS had reported monthly to the Quality Assurance Performance Improvement (QAPI) program the infection control tracking and trending: -Those records had not been attached to the QAPI notes. -The QAPI notes had only indicated how many infections had been present. No other information was available. -The new DNS had been unable to locate any infection control records. -The executive director (ED) had been unable to make contact with the previous DNS to assist in locating those records. Those missing records had included:	F 441	has been hired and is part of this job description to manage the infection control program. She begins her duties 9/13/15. She will be oriented to managing the infection control program for facility and preventing illness. B. All aides will be re-educated on aseptic technique and residents with CDiff will not receive whirlpool but a shower. Instructions for disinfection after a shower for someone with CDiff will be posted in the bathroom. <i>*Education will be provided by the DCE 10/9/15. SW/SPOTT/EL</i> C. Cleaning of fans in the hallway and resident rooms has been added to monthly housekeeping 3.) A. ED will review QAPI minutes monthly for 3 months for evidence that infections are monitored, trended, preventions in place and reported.	

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F 441	<p>Continued From page 25</p> <ul style="list-style-type: none"> -Infection tracking for all facility residents for the past year. -All tracking of resident antibiotic use in the facility. -The data analysis that would have assisted in the determination of infection origin and staff practices. -Communicable disease reporting. *There had been no way to locate the missing records at that time. *Facility staff was able to use the online infection control policies electronically. <p>Review of the provider's December 2014 Infection Control Program policy revealed:</p> <ul style="list-style-type: none"> *An effective infection prevention and control program was necessary to control the spread of infections and/or outbreaks. *Program development and oversight emphasized the prevention and management of infections. *Program oversight involved: <ul style="list-style-type: none"> -Establishing goals and priorities for the program. -Planning, and implementing strategies to achieve the goals. -Monitoring the implementation of the program, including the interdisciplinary team's infection control practices. -Responding to errors, problems, or other identified issues. <p>2. Observation on 9/9/15 at 10:40 a.m. of certified nursing assistants (CNA) A and D performing personal care and Foley catheter (tube to drain urine) care on resident 1 revealed CNA C:</p> <ul style="list-style-type: none"> *Washed her hands and put on gloves. *Emptied the urine from the urine collection bag. *Used an alcohol wipe to clean around the tubing used to empty the urine and reclosed the bag. 	F 441	<p>competency for aseptic technique with 3 staff weekly for 3 weeks and then 1 per week for 2 months to evaluate and provide direct education and intervention. DCE or designee will report results monthly to QAPI. The first report will be given October 27, 2015.</p> <p>B. DCE or designee will audit/competency whirlpool use and proper shower disinfectant when facility has a resident with CDiff and provide immediate retraining if indicated. Competency/audit will be completed weekly when there is a Cdiff resident and DCE or designee will report to QAPI monthly with the first report scheduled for 10/27/15.</p> <p>C. Housekeeping Supervisor will audit that fans were cleaned monthly x 3 months and report to QAPI. First report is scheduled for October 27, 2015.</p>	10/16/15

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F 441	<p>Continued From page 26</p> <ul style="list-style-type: none"> *Washed her hands and put on fresh gloves before removing a colostomy bag (to collect fecal matter) and cleaning the site. *Washed her hands and put on fresh gloves. *Washed resident 1's underarms and assisted with putting on her shirt. *With those same gloves she: <ul style="list-style-type: none"> -Bagged the resident's clothing and trash, then closed those bags. -Pulled off the resident's brief. -Obtained a disposable cleaning cloth. -Sprayed the skin cleaner on the cloth and used her gloved hand to smear the cleaner solution over the cloth. -Wiped the resident's groin (area below lower abdomen and at the top of the thighs). -Used the same cloth to wipe the perineum (private area) and around the catheter. -Pulled on the brief and clothing. -Removed her gloves and washed her hands. <p>Interview at that time with CNA C revealed she normally used an alcohol wipe to clean around the catheter insertion site, but had not done it that way today.</p> <p>Interview on 9/10/15 at 11:00 a.m. with the DNS revealed she would have expected the CNA to wash her hands and apply fresh gloves before she cleaned the catheter site.</p> <p>Review of the provider's January 2015 Catheter Care, Indwelling Catheter policy revealed the CNA was to have:</p> <ul style="list-style-type: none"> *Put on gloves and washed the perineum. *Washed hands and gathered equipment. *Cleansed the area around the catheter site well. *Rinsed the site well. *Applied antiseptic ointment to the catheter 	F 441		

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F 441	<p>Continued From page 27</p> <p>insertion site as ordered by the physician. *Removed gloves.</p> <p>3. Interview on 9/9/15 at 11:35 a.m. with bath aide A regarding cleaning a whirlpool bath revealed: *She used the Disinfecting the Tub/Chair policy attached to the wall of the tub room. *She used A-456-II (a quaternary [type of disinfectant] cleaner that disinfects bacteria and fungus). *She had bathed residents who had C-diff infections. *After bathing those residents with C-diff she used the same A-456-II quaternary cleaner to disinfect the whirlpool bath. *There was no bleach cleaner in the bath room.</p> <p>Review of the provider's undated Disinfecting the Tub/Chair policy revealed *After a bath the bath aide was to have used the disinfectant solution using the disinfect button on the the whirlpool tub. *There were no directions for disinfecting the whirlpool bath tub after bathing a resident with C-diff.</p> <p>Interview on 9/10/15 at 11:00 a.m. with the DNS revealed: *Her expectation had been residents with C-diff could bathe in the whirlpool bathtub as long as it had been cleaned appropriately using a bleach product. *Her expectation was the bath aide would use the provider's bleach disinfectant to clean the whirlpool bath tub after bathing a resident with a C-diff infection.</p> <p>Review of the provider's undated Clostridium</p>	F 441			

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F 441	<p>Continued From page 28</p> <p>Difficile Environmental Cleaning and Disinfection Guidelines revealed:</p> <ul style="list-style-type: none"> *Cleaning products to have been used to disinfect for a resident with C-diff had included: <ul style="list-style-type: none"> -Fresh Breeze TB R.T.U. (a detergent disinfectant). -Dispatch Hospital Cleaner Disinfectant Towels with Bleach. -Commercial Solutions Ultra Clorox Germicidal Bleach. *The policy had listed directions for cleaning a shower stall. *There was no documentation in the policy for cleaning a whirlpool bathtub. <p>Surveyor: 35625</p> <p>4. Observation on 9/10/15 from 8:30 a.m. to 9:20 a.m. revealed:</p> <ul style="list-style-type: none"> *Two overhead oscillating fans in the 100/east hallway had a layer of dark gray dust on the blades and on the outside frame. *Two overhead oscillating fans in the 200/north hallway had a layer of dark gray dust present on the blades and the outside frame. *One overhead oscillating fan in the 300/west hallway had a layer of dark gray dust on the blades and on the outside frame. *The fan in resident room 201 had a thick layer of dark gray dust on the blades, on the outside frame, and an approximately ten centimeter long piece of dust extending from the fan. *The fan in resident room 303 had a layer of dark gray dust on the blades and on the outside frame. *All of the above fans were in operation at the time of the observation. <p>Interview on 9/10/15 at 10:30 a.m. with the interim maintenance person revealed there was</p>	F 441		

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F 441	Continued From page 29 no documentation of a cleaning schedule for the above oscillating fans.	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435049	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2015
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/10/15. Golden LivingCenter-Salem was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Ronnica J Smith* TITLE *Executive Director* (X6) DATE *10/1/15*

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

OCT 08 2015

LSC

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10674 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/10/2015
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S 000	Initial Comments Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 9/8/15 through 9/10/15. Golden LivingCenter - Salem was found not in compliance with the following requirements: S210 and S355.	S 000	*Addendums noted with an asterisk per 10/29/15 per telephone with facility administrator. EMPLOYEE HEALTH PROGRAM SWISDDO/H/EL 1.) Statement that employee was free from communicable disease was obtained for employee A, F and I. TB was completed for employee I. First step was given by DNS on 9/10/15. SWISDDO/H/EL	9/11/15 SWISDDO/H/EL
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to complete health evaluations for three of three new employees (A, I, and the social services coordinator [SSC]). Findings include:	S 210	Every new employee could be at risk for missing information. Reviewed new staff since January 1, 2015 and none identified. 2.) Director of Clinical Education and Director of Records have been responsibility for on boarding new staff. As part of the first day of orientation, the tb will be completed and employee will completed the free of communicable diseases form. 3.) The Director of Records will audit new hire files to ensure tb and free from communicable disease form is completed and placed in the personnel file. 7EN SWISDDO/H/EL	

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

TITLE

(X6) DATE

Deonnica J Smith

Executive Director

10/1/15

OCT 08 2015

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10674 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2015
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 210	Continued From page 1 1. Review of certified nursing assistant (CNA) A's employee file revealed she had been hired on 2/24/15. She had completed and signed a health evaluation form utilized for determining freedom from communicable disease. There was no documentation a licensed health professional had reviewed it. Review of CNA I's employee file revealed she had been hired on 6/2/15. There was no documentation a health evaluation had been completed. Review of the SSC employee file revealed she had been hired on 7/13/15. There was no documentation a health evaluation had been completed. Interview on 9/9/15 at 1:05 p.m. with the executive director revealed she was unaware health evaluations had to be completed. That was why they had not been done for CNAs A and I and the SSC.	S 210	The audit will be completed monthly x 3 months. The Director of Records will report compliance to QAPI monthly. The first QAPI report will be October 27, 2015. <i>* Results of audits will be brought to the monthly QAPI meetings for a period of 3 months or until the committee feels no further monitoring is required. SW/SDDO/H/EL</i>	<i>10/16/15</i>
S 355	44:04:12:05 PROVISION OF SOCIAL SERVICES A nursing facility must provide or make arrangements to provide social services for each resident as needed. A staff social worker or social service designee must be designated as responsible to facilitate the provision of social services. If the staff member is not a social worker, the facility must have a written agreement with a social worker for consultation and assistance to be provided on a regularly scheduled basis but at least quarterly.	S 355	PROVISION OF SOCIAL SERVICES 1.) A contract was secured with a licensed social worker. <i>on 10/1/15 and Brynn Dickrel, LSW signed on 10/14/15. SW/SDDO/H/EL</i> No additional risk is present.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10674 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2015
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - SALEM	STREET ADDRESS, CITY, STATE, ZIP CODE 500 COLONIAL DR SALEM, SD 57058
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 355	<p>Continued From page 2</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to have a written agreement with a licensed social worker to provide consultation to the social services coordinator (SSC) at least quarterly. Findings include:</p> <p>1. Review of the SSC employee file revealed she had been hired on 7/13/15.</p> <p>Interview on 9/10/15 at 1:05 p.m. with the executive director (ED) and SSC revealed. *They had planned to have a social worker from another facility come and consult, but she had not been officially licensed yet. *They now planned to have a licensed social worker from a Sioux Falls facility come and consult with the SSC. -When asked the name of that person, the ED could not recall her name. *When asked about the written agreement for that individual to provide consultation the ED stated "It's a verbal contract." *They did not have a written agreement with a licensed social worker to provide consultation for the SSC.</p>	S 355	<p>2.) A contract was secured with a licensed social worker.</p> <p>3.) QI is complete as contract is obtained and current.</p>	10/16/15