

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451	
(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: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/14/16 through 6/16/16. Golden LivingCenter - Ipswich was found not in compliance with the following requirement: F441.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	F441 - INFECTION CONTROL, PREVENT SPREAD, LINENS 1. The Director of Nursing, environmental supervisor and IDT reviewed and revised the facility policy and procedure related to the cleaning and maintenance of the whirlpool tubs. Posted manufacturers cleaning instructions in each tub room . All residents have potential to be effected by this process. 2. The Director of Nursing completed education to all bath aides related to the cleaning and maintenance of the whirlpool tubs. 3. The Director of Nursing or designee will perform audits of tub cleanings. Audits will be completed weekly for 4 weeks, then monthly for 3 months. Results of these audits will be presented by the Administrator to monthly QAPI committee for review and recommendation. 4. Substantial compliance achieved	7/7/16

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

TITLE

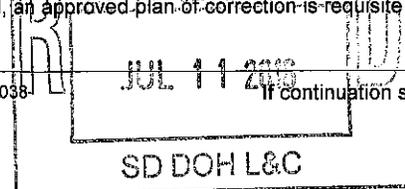
(X6) DATE

[Signature]

Executive Director

7-8-16

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: 06/28/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451		
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F 441	<p>Continued From page 1</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, manufacturer's instructions review, and procedure review, the provider failed to follow manufacturer's instructions for disinfecting one of two whirlpool tubs located in the 100 hall during one of one observed whirlpool cleaning by certified nursing assistant (CNA) A. Findings include:</p> <p>1. Observation on 6/14/16 at 11:19 a.m. with CNA A during disinfecting of the whirlpool located in the 100 hall revealed: *She had: -Sprayed the whirlpool chair with pre-mixed disinfectant solution. -Added approximately one gallon of pre-mixed disinfectant solution to the foot well of the whirlpool tub. -Added water in the foot well until it covered the water intake. -Turned the air jets on. -Sprayed the interior surfaces of the whirlpool with pre-mixed disinfectant solution. -Scrubbed the interior surfaces of the whirlpool with a brush for less than one minute. -Stated she would let the air jets run for ten minutes.</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451	
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F 441	<p>Continued From page 2</p> <p>*The chair and some of the interior surfaces of the whirlpool tub had dried at 11:25 a.m. *She confirmed those areas were dry.</p> <p>Interview on 6/14/16 at 11:30 a.m. with CNA A revealed she: *Had followed the directions on their Tub Sanitation Procedure that was posted in the shower room. *Confirmed those instructions were to: -"Let whirlpool run for 10 minutes." -"While whirlpool is running spray the inner surface of tub with the premixed cleaner and thoroughly scrub inside of tub." *Agreed the disinfecting directions on the container of disinfectant instructed a "10-minute contact time." *Stated she would not have monitored the whirlpool or chair surfaces to ensure they had remained wet for a ten minute contact time.</p> <p>Continued observation and interview on 6/14/16 at 11:34 a.m. with CNA A revealed she had: *Drained the tub. *Lowered the whirlpool chair into the tub. *Added approximately two gallons of disinfectant solution to the foot well of the whirlpool tub. *Filled the tub with water until it covered the top of the chair. *Turned the air jets on. *Stated she would let the air jets run for ten to fifteen minutes, then drain and rinse the tub. *Agreed adding that amount of water to the tub would dilute the disinfectant beyond the manufacturer's instructions reducing its effectiveness.</p> <p>Interview on 6/14/16 at 12:50 p.m. and at 1:30 p.m. with the environmental services supervisor</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451		
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F 441	<p>Continued From page 3</p> <p>revealed he:</p> <ul style="list-style-type: none"> *Had condensed the whirlpool manufacturer's instructions to create their Tub Sanitation Procedure. *Confirmed the whirlpool manufacturer's instructions were to "Allow for proper disinfectant contact time (Usually 10 minutes or as recommended by the disinfectant's manufacturer.)" *He had not read the disinfectant manufacturer's instructions when he created the Tub Sanitation Procedure. *Confirmed the disinfectant manufacturer's instructions were for surfaces to remain wet for ten minutes. <p>Interview on 6/16/16 at 9:48 a.m. with the interim director of nursing (DON) confirmed:</p> <ul style="list-style-type: none"> *Their Tub Sanitation Procedure did not follow the disinfectant manufacturer's instructions. * CNA A did not follow the correct procedure to disinfect the whirlpool tub according to the disinfectant manufacturer's instructions. <p>Review of the provider's revised 7/13/14 Tub Sanitation Procedure revealed to:</p> <ul style="list-style-type: none"> -"Let whirlpool run for 10 minutes." -"While whirlpool is running spray the inner surface of tub with the premixed cleaner and thoroughly scrub inside of tub." <p>Review of the undated manufacturer's Penner whirlpool disinfecting instructions revealed to "Allow for proper disinfectant contact time (Usually 10 minutes or as recommended by the disinfectant's manufacturer.)"</p> <p>Review of the undated manufacturer's instructions for the Classic Whirlpool Disinfectant</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451		
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F 441	Continued From page 4 and Cleanser revealed to mix "2 fluid ounces per gallon of water and a 10-minute contact time."	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435055	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/15/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted from 6/14/16 through 6/15/16. Golden LivingCenter-Ipswich 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 K029 and K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure one of four exits on the ground floor (main entrance) was readily accessible at all times. Findings include: 1. Observation at 8:30 a.m. on 6/14/16 revealed the main entrance door was equipped with a magnet lock and a sign stating it was a delayed egress-type door. Testing of the door at the time of the observation revealed the door release was not activated by firmly pushing against the bar across the width of the door. Interview with the maintenance supervisor at the time of the observation confirmed that finding. Subsequent phone conversation with the installer revealed the thumbwheel on the door that controlled the	K 038	K038 - NFPA 101 LIFE SAFETY CODE STANDARD 1. Thumbwheel adjusted to properly operate the maglock emergency process on 6/14/16. Set screws have been ordered and will be installed so thumbwheel cannot be manipulated. All residents have potential to be effected by this process. A durable tamper resistant sign installed 7/5/16. All residents have potential to be effected by this process. 2. Audit other maglock equipped doors for proper operation and presence of set screws. Audit other maglock equipped doors for proper signage.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Executive Director* (X6) DATE *7-8-16*

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

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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH			STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD 57451		
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K 038	<p>Continued From page 1</p> <p>strength of the magnet had been turned up too strong. Further observation revealed a set screw which would lock the thumbwheel in place (and restrict easy manipulation of the magnet's strength) was missing. The magnet was adjusted to release the door as required during the survey. The maintenance supervisor stated the magnetic lock at the service entrance was a similar installation.</p> <p>2. Observation at 8:20 a.m. on 6/14/16 revealed the main entrance door had a sign stating the magnetically locked door was a delayed egress door. The paper sign was in a plastic sleeve taped to the door glass. Interview with the maintenance supervisor at the time of the observation revealed he was unaware the sign needed to be a durable sign (tamper resistant) affixed to the door. He further revealed the sign for the magnetically locked door at the service entrance was similar.</p> <p>The deficiency had the potential to affect all occupants in that smoke compartment.</p> <p>Ref: 2000 NFPA 101 Section 19.2, 7.2.1.6.1</p>	K 038	<p>3. Maintenance Supervisor will conduct a one-time audit of the function of all maglocks to ensure emergency egress. Results of audit will be presented to QAPI committee for review and recommendation.</p> <p>Maintenance Supervisor will conduct a one-time audit of durable tamper resistant signage on maglock equipped doors. Results of audit will be presented to QAPI committee for review and recommendation.</p> <p>4. Substantial compliance achieved</p>	7/8/16	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435055	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 6/15/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DRIVE POST OFFICE BOX 728 IPSWICH, SD
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ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES

ORIGINAL

K 029

NFPA 101 LIFE SAFETY CODE STANDARD

One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:

Surveyor: 18087

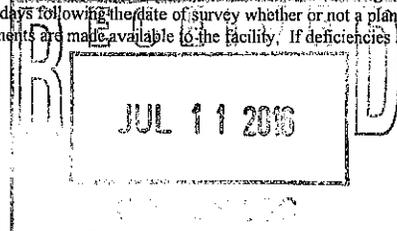
Based on observation, testing, and interview, the provider failed to maintain proper separation of hazardous areas. The laundry soiled linen room corridor door would not latch with the operation of the closer. Findings include:

1. Observation at 10:30 a.m. on 6/14/16 revealed the one hour fire-rated door for the laundry soiled linen room corridor door would not latch with the operation of the closer. Testing of the door with the closer revealed the leading edge of the door struck the frame and bound the door. Interview with the maintenance supervisor at the time of the observation revealed the door was installed in a wall with metal studs. He said he could move the frame with a sledgehammer to allow the door to clear the frame and latch with the operation of the closer. He further revealed he understood that would not be a lasting solution to the problem.

The deficiency had the potential to affect 100% of the occupants of the service wing.

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The above isolated deficiencies pose no actual harm to the residents



ORIGINAL

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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10635	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/16/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - IPSWICH	STREET ADDRESS, CITY, STATE, ZIP CODE 617 BLOEMENDAAL DR POST OFFICE BOX 728 IPSWICH, SD 57451
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S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/14/16 through 6/16/16. Golden LivingCenter - Ipswich was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Executive Director

(X6) DATE

7-8-16

