

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>
---	---

(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 3/17/16 per email w/ facility administrator.</i></p> <p>Surveyor: 34030 <i>SW/SDDOH/EL</i></p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/1/16 through 2/3/16. Golden LivingCenter - Groton was found not in compliance with the following requirements: F176, F221, F248, F280, and F309.</p>	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 176 SS=D	<p><b>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</b></p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to follow their policy for resident self-administration of medications for: *One of one sampled resident (7) observed during one of one nebulizer (breathing medication) treatment. *Two of two sampled residents (7 and 10) who had medications at their bedsides. Findings include:</p> <p>1. Observation on 2/3/16 at 11:00 a.m. through 11:15 a.m. with resident 7 and registered nurse (RN) A in the resident's room revealed: *There was a bottle of Dakins (liquid medication for wounds) solution and a bottle of Providine/Iodine (liquid medication for wounds)</p>	F 176	<p>F176 Resident Self-Administer Drugs If Deemed Safe</p> <p>1. Medications that were found in Resident 7's room were removed on 2/3/16. Resident was reassessed regarding Self-Administration of Medications. Resident was found to be capable of self-administering nebulizer treatments. Physician order in place and care plan updated.</p> <p>Medications in Resident 10's room were removed on 2/3/16.</p> <p>All nursing staff were educated on 2/11/16 of policy and procedure regarding Medication Administration-Preparation and General Guidelines for Resident Self Administration of Medications as well as reviewed the Medication Self-Administration Assessment.</p> <p>Any resident that is currently doing self-administration of medications has a potential to be affected.</p> <p>2. Upon admission or at any time a resident after admission wishes to self administer medications, an assessment will be conducted by the Interdisciplinary Team of the resident's cognitive, physical, and visual ability to carry out the responsibility during the care planning process. If deemed safe, an order will be obtained, as well as it will be care-planned.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/25/16</i>
---	------------------------------------	-----------------------------

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: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 176	<p>Continued From page 1 solution on a shelf. -The Dakins had expired in December 2015. *RN A stated she must have brought them back from the hospital at some time. -She did not use those medications. *The resident confirmed those medications had been from the hospital, and she did not use them anymore. *RN A put the resident's nebulizer medication into the nebulizer chamber and started the machine. *She handed the nebulizer set to the resident and then left the room. *After leaving the room RNA stated the resident was okay to self-administer her nebulizer treatment after it had been set-up.</p> <p>Review of resident 7's medical record with RN A revealed her: *Last signed 1/25/16 physician's orders did not mention she could self-administer medications after set-up or have medications in her room. *Last revised 1/4/16 care plan did not mention she was okay to self-administer medications after set-up or have medications in her room. *1/20/16 clinical health status assessment by nursing was checked she wished to self-administer medications, and they should have proceeded to do a Self Administration Assessment. *Self-administration assessment had been completed on 10/30/15. At that time she was unable to self-administer medications or keep medications in her room. -There were no further Self Administration Assessments in her record.</p> <p>Interview on 2/3/16 at 11:20 a.m. with RN A and the director of nursing (DON) regarding resident 7 confirmed she should have:</p>	F 176	<p>The Interdisciplinary Team will review residents quarterly, that are currently doing Self Administration of Medications to ensure that the last assessment was accurate. This will be based on if they have had a significant change in condition since their last assessment. If a significant change has occurred, the team will verify that a new assessment was completed at time of change of condition.</p> <p>3. Audits will be performed by the Interim Director of Nursing or her designee to ensure residents that are performing self administration of medications have had a self administration of medications assessment stating that they are deemed safe to do so, that the resident has not had a significant change of condition since last assessment, that there is a physician's order for the medication to be self administered, and that the care plan reflects the order and the assessment. This audit will be conducted by March 4<sup>th</sup>, 2016 on all residents who are self administering medications. Ongoing monitoring will be done with the quarterly reviews of the residents as well as with any significant change in condition.</p> <p>Results of these audits will be presented by the Interim Director of Nursing to the monthly QAPI committee for review and recommendation.</p>		



\*3/24/16  
SW/SDDOHL

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 176	<p>Continued From page 2</p> <p>*Had a self-administration assessment stating she was able to self-administer medications after set-up or could have kept medications in her room.</p> <p>*Been re-assessed for self administration according to her 1/20/16 clinical health status assessment.</p> <p>*Had physician's orders stating she was able to self-administer medications after set-up.</p> <p>Surveyor: 32573 2. Review of resident 10's complete medical record revealed:</p> <p>*She had a self-administration assessment done on 8/13/13 and had been found safe to: -Self administer medications after nurses set it up. -Keep Vicks Vaporub at her bedside table.</p> <p>*She had been assessed for self-administration on 1/14/16 and: -Had not wanted to self-administer medications.</p> <p>*She had a 10/15/12 order for Vicks Vaporub that "may be kept at bedside per Dr. [name] orders."</p> <p>*She had a BIMs (brief interview for mental status) score (assessment for cognitive function) of three. -A score of three indicated severe cognitive impairment.</p> <p>Observation on 2/3/16 at 10:30 a.m. revealed a jar of Vicks Vaporub had been sitting on resident 10's bedside table.</p> <p>Interview on 2/3/16 at 10:15 a.m. with RN A revealed she had done the self-administration assessment on 8/13/13 specifically for the Vicks Vaporub to be left in resident 10's room. She thought a new assessment might not have been done because resident 10 had been marked as</p>	F 176			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 176	Continued From page 3 not wanting to self-administer medications. The Vaporub should have been removed at that time.  Interview on 2/3/16 at 12:50 p.m. with the director of nursing revealed she had been unsure if self-administration assessments included leaving the Vaporub on resident 10's bedside table. The wording for the assessments had been confusing.  Surveyor: 35237 Review of the provider's May 2012 Self-Administration of Medications policy revealed: *"If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry our this responsibility during the care planning process." *"For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on an ongoing basis or when there is a significant change in condition." *"The results of the interdisciplinary team assessment of resident skills and the determination regarding bedside storage are recorded in the resident's medical record, on the care plan." *"If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted." *"Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self administer."	F 176			
F 221	483.13(a) RIGHT TO BE FREE FROM	F 221			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 221 SS=D	<p>Continued From page 4 <b>PHYSICAL RESTRAINTS</b></p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 36413 Based on observation, interview, record review, and policy review, the provider failed to ensure restraint assessments were completed, physician orders were obtained, and restraints had been care planned prior to initiation of a seat belt for one of one sampled resident (9) who used a seat belt. Findings include:</p> <p>1. Observation on 2/2/16 at 9 a.m. revealed the resident had a seat belt around her waist and fastened while in the wheelchair.</p> <p>Observation on 2/3/16 at 8:10 a.m. and 10:35 a.m. revealed resident could not remove seat belt when asked to.</p> <p>Interview on 2/3/16 at 8:30 a.m. with certified nursing assistant (CNA) J revealed she had been recently trained to put on resident's seat belt when she was in the wheelchair.</p> <p>Interview on 2/3/16 at 8:40 a.m. with Alzheimer's Care Director revealed she thought the wheelchair had been changed when she was absent and she did not know why she had the seat belt. She agreed that the seat belt would be considered a restraint.</p>	F 221	<p>F221 Right To Be Free From Physical Restraints</p> <p>1. Resident 9 was removed from wheelchair with seatbelt and a new wheelchair was provided for her without a seatbelt on 2/3/16.</p> <p>All staff were educated on 2/11/16 of policy and procedure regarding Restraint Evaluation and Utilization Guidelines as well as the Physical Restraint Review Procedures.</p> <p>All residents have the potential to be affected.</p> <p>2. If all other attempts are made and documented that they are unsuccessful and if it is deemed necessary that a resident requires a physical restraint the following will occur:</p> <ul style="list-style-type: none"> <li>a) Resident will properly be assessed for the safe use of a physical restraint with the use of a restraint assessment.</li> <li>b) Resident's family will be notified of need for a physical restraint and written/verbal consent will be obtained and documented.</li> <li>c) A Physician's order will be obtained and documented.</li> <li>d) Staff will be educated regarding the safe and proper use of a restraint.</li> <li>e) Resident's care plan will be updated with information regarding the use of a restraint.</li> <li>f) Weekly documentation will occur regarding purpose of restraint, resident's response to restraint, and frequency of release of restraint.</li> </ul> <p>3. Proper use of restraints will be monitored by Interim Director of Nursing or her designee. Restraints will be monitored on a daily basis for 12 weeks. Restraint audits will be conducted once a week for 12 weeks.</p> <p>Results of these audits will be presented by the Interim Director of Nursing to the monthly QAPI committee for review and recommendation.</p>		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 221	Continued From page 6 should have been on the chart. *The care plan should have reflected current use of restraint including: -Type of restraint -Frequency of release. -Risks of restraint use -Evidence of reduction and/or elimination. *Ensure the nursing notes included weekly documentation regarding the reason for restraint use and that the restraint was being released as per physician's order and to document the resident's response to the restraint use.	F 221			
F 248 SS=D	<b>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</b>  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to ensure one of three sampled residents (9) who resided in the Alzheimer's Care Unit (ACU) received activities to address her individual needs. Findings include:  Surveyor: 33265 1. Observation on 2/1/16 at 5:30 p.m. in the ACU revealed: *Eleven of the twelve residents were in the dining room and the television was on. *The twelfth resident, resident 9 was in her bed	F 248	<b>F248 Activities Meet Interests/Needs of Each Resident</b>  1. Resident #9's Individual Programming was reviewed on 2/4/16. One on one activities were put into place effective 2/23/16 after the Administrator, the Interim Director of Nursing, the Social Services Director, the Qualified Activity Director, the Alzheimer's Care Director, and the Dietary Services Manager met on 2/19/16 to review the policies and procedures about ensuring the needs of Resident #9 as well as ensuring the residents as a group as a whole are met.  All staff were educated on 2/11/16 of policy and procedure regarding the guidelines for Caregiver interaction with Dementia.  The Alzheimer's Care Director and the Qualified Activity Director were assigned training as well, on the Learning Center called ALZ Therapeutic Activity Programming for Persons with Dementia. This training was completed by both staff members before 2/19/16.  The Administrator, the Interim Director of Nursing, the Social Services Director, the Qualified Activity Director, the Alzheimer's Care Director, and the Dietary Services Manager met on 2/19/16 to review the policies and procedures about ensuring the needs of individuals as well as the group as a whole are met.  All residents have potential to be affected. Interdisciplinary Team will identify residents who		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>	
(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 248	<p>Continued From page 7 with her eyes closed.</p> <p>Observation on 2/2/16 from 8:00 a.m. through 9:25 a.m. in the secured unit revealed: *At 8:00 a.m. from the dining room you could hear resident 9 yelling from down the hall. *At 8:30 a.m. resident 9 was in the living room area at the opposite end of the hall from the dining room. -She was in her wheelchair in front of a bookcase. -There was a seatbelt fastened around her in the wheelchair. -The television was on. -She was bending over reaching for books on the second shelf of the bookcase and throwing the books as far as she could all over the room. *At 9:25 a.m. staff members noticed resident 9 was pulling the books off the shelf in the living room. -She was moved to her room.</p> <p>Surveyor: 35237 Interview of registered nurse (RN) A and observation of resident 9 in the ACU on 2/2/16 at 12:15 p.m. revealed: *She was sitting alone in the living room area at the end of the hall in her wheelchair in front of the television and was loudly yelling out repeated phrases. *She stated the resident frequently yelled out like that and was in the lounge area instead of the dining room due to disrupting other residents at meal time. *Nursing staff were busy in the dining room at that time.</p> <p>Observation and interview on 2/3/16 at 8:00 a.m. with resident 9 revealed she:</p>	F 248	<p>could benefit from personalized 1:1 programing based on their group participation.</p> <p>2. Upon admission and ongoing throughout a resident's stay; including change of conditions, quarterly reviews, and annual reviews; structured individual programming and interventions will be developed based on each resident's history and assessed needs and preferences. The individual programming will address their social, emotional, physical, and cognitive functioning needs.</p> <p>3. The Interim DNS or her designee will monitor activity participation to ensure that the individual programming meets the resident's needs. The Interim Director of Nursing or her designee will also monitor the 1:1 documentation to ensure that the 1:1's are getting done for residents who do not participate in one or more group activities a day. These audits will be conducted once a week for 12 weeks.</p> <p>Results of these audits will be presented by the Interim Director of Nursing to the monthly QAPI committee for review and recommendation.</p> <p> *3/24/16 SW/SDOH/EL</p>	

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 248	<p>Continued From page 8</p> <ul style="list-style-type: none"> <li>*Was sitting alone in her room in her wheelchair with the radio on.</li> <li>*Was able to answer questions when asked.</li> <li>*Had a loud voice and repeated statements frequently.</li> <li>*Appeared to calm down when talking one-on-one.</li> <li>*Clapped her hands repeatedly and had backed her wheelchair up against a wall.</li> </ul> <p>Review of the large activity calendar in the dining room for the ACU revealed:</p> <ul style="list-style-type: none"> <li>*There was only one specific activity listed for each day. On Monday through Friday that activity was scheduled for 2:00 p.m. or 3:00 p.m.</li> <li>*On Saturday and Sunday a specific time for the activity was not listed.</li> <li>*Activities on the calendar included: <ul style="list-style-type: none"> <li>-Puzzles.</li> <li>-Sensory box.</li> <li>-Coloring.</li> <li>-Expand your mind.</li> <li>-Arts and crafts.</li> <li>-Animal fit kit.</li> <li>-Art fit kit.</li> </ul> </li> <li>*Exercise was daily from 10:45 a.m. through 11:00 a.m.</li> <li>*Snack and chat was daily at 3:00 p.m.</li> <li>-That was scheduled for the same time as the one scheduled activity could occur at.</li> </ul> <p>Random observations on 2/1/16 through 2/3/16 revealed:</p> <ul style="list-style-type: none"> <li>*Exercises were conducted in the main lounge area of the facility outside of the ACU.</li> <li>*Only three residents from the ACU had attended those exercises on 2/3/16.</li> <li>*Resident 9 had not attended exercises or been involved in any therapeutic activities.</li> </ul>	F 248			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 248	<p>Continued From page 9</p> <p>-She sat in front of the TV or listened to the radio at times.</p> <p>Interview on 2/3/16 at 8:20 a.m. with the ACU director regarding resident 9 revealed:</p> <ul style="list-style-type: none"> <li>*She frequently yelled out and was disruptive to the other residents.</li> <li>*She sat in the living room often with the television on and liked to listen to the radio at times.</li> <li>*Sometimes they set out the jewelry box for her to go through.</li> <li>*The large activity calendar in the dining room was their scheduled activity calendar for the ACU residents.</li> <li>*She had been the ACU director for the last few months and denied having additional training for working in the unit.</li> <li>*There was typically only one CNA during the day, evening, and night working in the ACU. The nurse relieved that CNA for break times.</li> <li>*She worked daytime during week days in the ACU.</li> <li>*She agreed the resident required more individualized therapeutic programming due to her behaviors and cognition.</li> </ul> <p>Interview on 2/3/16 at 8:30 a.m. with CNA J in the ACU revealed:</p> <ul style="list-style-type: none"> <li>*She normally did not work in the ACU.</li> <li>*There was usually just one CNA on the unit and the ACU director during the week days.</li> <li>*The nurse was only on the unit when passing medications and to cover for the CNA to take breaks.</li> <li>*It was difficult to do therapeutic activities in the ACU when there was only one CNA.</li> <li>*Resident 9 should have had more one-to-one or other therapeutic activities to keep her busy.</li> </ul>	F 248		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>	
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 248	<p>Continued From page 10</p> <p>Interview on 2/3/16 at 11:40 a.m. with the activity director revealed:            *She did not participate or schedule any acitivities in the ACU, only the other units of the building.            *The ACU staff were responsible for the activities in that unit.            *Only a few residents from the ACU came out of the unit to attend activities.            *Resident 9 did not come out of the ACU for activities.            *She felt resident 9 calmed down and had less behaviors and yelling when someone had one-on-one interaction with her.            -She should have had more individualized activities and therapuetic programming due to her behaviors.            *All residents should have had their activities and interventions on their care plans.</p> <p>Review of resident 9's current care plan on 2/3/16 revealed there was no documentation regarding her specific activities, therapeutic programming, or any interventions that could have been utilized.</p> <p>Review of the provider's 2009 Recreation Services Guide: Individual Programming policy revealed:            **"Structured individual interventions will be developed based on each resident's history and assessed needs and preferences."            **"Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical, and cognitive functioning needs."            **"Examples of individualized activities might include any of the following:"            -"Sensory stimulation of cognitive therapy."            -"Social engagement."</p>	F 248		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>	
(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 248	Continued From page 11 -"Spiritual support, nurturing." -"Creative, task-oriented activities." -"Support of self-directed activity."	F 248		
F 280 SS=E	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.  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.  This REQUIREMENT is not met as evidenced by: Surveyor: 35237 A. Based on observation, interview, record review, and manual review, the provider failed to ensure five of ten sampled residents' (1, 2, 4, 7, and 10) care plans had been reviewed and revised to reflect their current needs. Findings include:	F 280	F280 Right to Participate Planning Care-Revise CP  1. Resident 7's care plan now reflects the resident's current level of physical functioning. The medications were removed from resident's room on 2/3/16. Resident was reassessed regarding Self-Administration of Medications. Resident was found to be capable of self-administering nebulizer treatments. Physician order in place and care plan updated.  Resident 1's wander guard has been removed from the care plan as the wander guard is no longer in place after the physician discontinued it on 1/22/16.  Resident 10's care plan has been revised to show proper diet order of regular. Resident's care plan was updated to show proper level of assistance and care for toileting.  Resident # 2's care plan has been updated to reflect proper dressing change orders. The care plan for resident to sit alone in dining room is no longer in place.  Resident # 4's care plan was updated to reflect her wishes of sitting alone in the dining room. The care plan for the wander guard was also removed to reflect the physician's order to discontinue the wander guard on 10/27/15.  Resident # 3's care plan is current to reflect the resident's current level of physical functioning. The care plan was also updated to address the pressure ulcer and leg sores. Resident's depression and interventions for that are now in place within the care plan. The resident's need for physical therapy services is updated within the care plan.	

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>	
(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)
F 280	<p>Continued From page 12</p> <p>1. Observation on 2/2/16 from 11:00 a.m. through 11:15 a.m. of resident 7 in her room revealed: *She got up independently from her bed and walked to the bathroom and back with a front-wheeled walker and no staff assistance. *She performed her own dressing and personal hygiene. *There was a bottle of Dakins (medication for wounds) solution and a bottle of Providine/Iodine (medication for wounds) solution on a shelf. *At 11:14 a.m. registered nurse (RN) A started a nebulizer (breathing medication) treatment for her then left the room leaving the resident to self-administer the nebulizer.</p> <p>Review of resident 7's last revised 1/4/16 care plan revealed: *No mention of her ability to self-administer medications after set-up by nursing or that she could have kept medications in her room. *The area for physical functioning deficit had not been revised since 11/18/15. -That section indicated she needed a wheelchair and extensive staff assistance with bed mobility, dressing, hygiene, toileting, and transferring.</p> <p>Interview on 2/2/16 at 3:45 p.m. with RN H revealed: *Resident 7's care plan had not been updated to reflect her current level of physical functioning and had not addressed her self-administration of medications. *Nursing staff should have referred to care plans to take care of the residents. *Charge nurses had not revised care plans, the Minimum Data Set (MDS) nurse was responsible for the care plans and revisions.</p> <p>Interview on 2/2/16 at 3:50 p.m. with the director</p>	F 280	<p>All staff were educated on 2/11/16 of guidelines and procedure in regards to creating, revising, and updating care plans.</p> <p>All residents have potential to be affected.</p> <p>2. Upon admission, an initial comprehensive care plan will be created and completed for each resident with the resident or the resident's family or legal representative, as well as the interdisciplinary team. The care plan will be reviewed, revised, and updated in correlation with each assessment and any significant changes to reflect their current needs on an ongoing basis, if appropriate.</p> <p>3. The Interim DNS or her designee will monitor compliance of creating, revising, and updating care plans to reflect each resident's current needs. Audits will be completed each week for 12 weeks. Ongoing monitoring will be done with the quarterly reviews of the residents or any significant change of condition of each resident.</p> <p>Results of these audits will be presented by the Interim Director of Nursing to the monthly QAPI committee for review and recommendation.</p> <p><i>* quarterly</i> <i>SW/SDD/HJEL</i></p> <p><i>3/24/16</i> <i>SW/SDD/HJEL</i></p>

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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	<p>Continued From page 13 of nursing (DON) regarding resident 7's care plan confirmed it had not been updated to reflect her current status or needs and should have been. A care plan policy was requested.</p> <p>Interview on 2/3/16 at 12:15 p.m. with the DON and administrator revealed: *The provider did not have a specific care plan policy. -They would have used the Resident Assessment Instrument manual for guidance. *They confirmed all residents' care plans should have been reviewed and revised periodically and reflected their current care needs.</p> <p>Surveyor: 32573 2. Review of resident 1's complete medical record revealed: *Her most current care plan had been a working care plan in her chart. -Updates had been hand written in. -Those updates had not been given a revision date. -A note stated she wore a Wanderguard with a target date of 4/26/16. *A physician's order discontinuing her Wanderguard on 1/22/16, because it had expired and was no longer being manufactured.</p> <p>3. Review of resident 10's complete medical record revealed: *Her 2/3/16 care plan revealed: -An intervention of "diet as ordered-regular mech [mechanical] soft" revised on 8/26/14. -An intervention of "toileting plan is independent with toileting" revised on 8/26/14. *A 12/7/15 physician's order of "diet changed to regular." *Her 1/14/16 Minimum Data Set (MDS)</p>	F 280			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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	<p>Continued From page 14 assessment had been coded as supervision and one person assist for toileting.</p> <p>Interview on 2/3/16 at 12:50 p.m. with the DON revealed: *She had been in the process of updating resident 1's care plan. *She had not been sure how to code toileting on her MDS, because sometimes she was independent. *She understood there had been some care plan issues with several residents.</p> <p>Surveyor: 36413 3. Observations on 2/1/16 at 5:45 p.m., 2/2/16 at 8 a.m. and at 11:45 a.m., and 2/3/16 at 8 a.m. and at 11:45 a.m. revealed resident 2 was seated at a table with another resident in the dining room.</p> <p>Review of resident 2's record revealed a physician's order dated 11/15/15 to changed the pressure ulcer dressing daily.</p> <p>Review of resident 2's 10/2/15 care plan revealed: *He desired to sit alone in the dining room. That intervention was dated 8\4\15. *His pressure ulcer dressing change was to be changed every three days. That intervention was dated 11/6/15. -It had not been updated to reflect the 11/15/15 physician's order.</p> <p>5. Observations on 2/1/16 at 5:45 p.m., on 2/2/16</p>	F 280			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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	<p>Continued From page 15 at 8 a.m. and at 11:45 a.m., and on 2/3/16 at 8 a.m. and 11:45 a.m. revealed resident 4 was seated by herself in the dining room.</p> <p>Observation on 2/1/16 at 4 p.m. revealed resident 4 did not have a wanderguard in place.</p> <p>Review of resident 4's 4/29/15 care plan revealed: *She preferred to have 1-2 table mates. *She had a wandergaurd in place and the nurse would have checked for placement each shift. That intervnenction was updated on 1/15/16.</p> <p>Review of resident 4's record revealed a physician's order to discontinue the wanderguard on 10/27/15.</p> <p>Interview on 2/3/16 at 8:10 with Director of ACU revealed she was unaware of resident 4 had a wandergaurd. Interview on 2/3/16 at 8:50 with the DON revealed resident 4 did not have a wandergaurd on.</p> <p>Surveyor: 35237 Review of the provider's October 2014 Resident Assessment Instrument (RAI), Version 3.0, Manual relating to care plans revealed "Nursing homes should also evaluate the appropriateness of the care plan after each Quarterly and SCQA [Significant Correction to Prior Quarterly] assessment and modify the care plan on an ongoing basis, if appropriate."</p> <p>Surveyor: 34030 B. Based on observation, interview, record review and policy review, the provider failed to complete an initial comprehensive care plan for one of one</p>	F 280		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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	<p>Continued From page 16 sampled resident (3). Findings include:</p> <p>1. Random observations from 2/2/16 to 2/3/16 of resident 3 revealed he was able to move from his recliner to the wheelchair by himself.</p> <p>Review of resident 3's medical record revealed: *An admission on 1/9/16. *He was admitted with a pressure ulcer on his bottom and sores on his legs. *He was being treated for depression. *He received physical therapy for strengthening. *A 1/15/16 initial Minimum Data Set (MDS) assessment to determine his care needs.</p> <p>Review of resident 3's 1/21/16 care plan revealed: *A temporary care plan with the following: -"Pressure ulcer risk. Bed mobility problem." -"Pain" with interventions. Did not specify type or location of pain. -"Assist of one" when moving from one area to another. *It had not been updated to reflect his current condition regarding his: -Ability to move without assistance. -Pressure ulcer and leg sores. -Depression and interventions. -Physical therapy. *The care plan did not include anything about his cognitive status nor any assistance required with bathing, hygiene, or dressing.</p> <p>Interview on 2/3/16 at 11:15 a.m. with the director of nursing regarding resident 3's care plan revealed: *She did the MDS assessments and care plans for the residents. *It had not been completed in a timely manner. It</p>	F 280		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 17 should have been completed by 1/22/16.  Review of the provider's October 2014 Care Plan Completion policy revealed: *"The care plan completion date must be either later than of the same date as the CAA [care area assessment, part of the MDS] completion date, but no later than 7 calendar days after the CAA completion date." *"The MDS completion date must be earlier than or the same date as the care plan completion date."	F 280			
F 309 SS=E	<b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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: 35237  Surveyor: 33265  Surveyor: 36413 Based on observation, interview, record review and policy review, the provider failed to ensure the individual needs related to behaviors, dining, and activities, were met for one of three sampled residents (9) in the Alzheimer's Care Unit (ACU). Findings include:	F 309	<b>F309 Provide Care/Services For Highest Well Being</b>  1. Resident #9's Individual Programming was reviewed on 2/4/16. One on one activities were put into place effective 2/23/16 after the Administrator, the Interim Director of Nursing, the Social Services Director, the Qualified Activity Director, the Alzheimer's Care Director, and the Dietary Services Manager met on 2/19/16 to review the policies and procedures about ensuring the needs of Resident #9 as well as ensuring the residents as a group as a whole are met. Resident 9 was removed from wheelchair with seatbelt and a new wheelchair was provided for her without a seatbelt on 2/3/16. Resident's care plan was updated to reflect that the resident will be fed in a timely manner and put in a non-stimulating environment by attempting to feed resident in dining room. If resident becomes agitated, resident will be removed to eat in resident room with staff assistance at that time. Care plan currently reflects the current needs of the resident.  All staff were educated on 2/11/16 of policy and procedure regarding the guidelines for Caregiver Interaction with Dementia.  The Alzheimer's Care Director and the Qualified Activity Director were assigned training as well, on the Learning Center called ALZ Therapeutic Activity Programming for Persons with Dementia. This training was completed by both staff members before 2/19/16.		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>	
(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 Surveyor: 33265 1. Observation and interview on 2/1/16 from 5:30 p.m. through 6:32 p.m. in the ACU revealed: *At 5:30 p.m.: -Resident 9 was in her bed with her eyes closed. -Certified nursing assistant (CNA) E said resident 9 had been acting out and had been removed from the dining room and put to bed. *At 5:45 p.m. the food arrived from the main kitchen and the meal was served. The two CNAs remained in the dining room until the meal was finished. *At 6:20 p.m. from the doorway you could hear an alarm going off. It was coming from resident 9's room. She was awake, yelling, and when observed, had both of her feet out of bed and on the mattress on the floor next to the bed. *At 6:37 p.m. CNA E was asked if resident 9 was going to get the evening meal. -She stated she was disruptive so was fed last and that she was going to get her now.</p> <p>Observation and interview on 2/2/16 from 8:00 a.m. through 9:25 a.m. in the ACU revealed: *At 8:00 a.m. you could hear resident 9 yelling from down the hall. *At 8:30 a.m. resident 9 was observed in her wheelchair in the living room area at the opposite end of the hall from the dining room. -She was bending over reaching for books and throwing the books all over the room. -No staff noticed until 9:25 a.m. at which time resident 9 was moved to her room. -The maintenance director started picking up the books and items thrown about the living room. He stated resident 9 had not done this before.</p> <p>Observation on 2/2/16 from 11:45 a.m. through 12:01 p.m. in the ACU revealed:</p>	F 309	<p>The Administrator, the Interim Director of Nursing, the Social Services Director, the Qualified Activity Director, the Alzheimer's Care Director, and the Dietary Services Manager met on 2/19/16 to review the policies and procedures about ensuring the needs of individuals as well as the group as a whole are met.</p> <p>All staff were educated on 2/11/16 of policy and procedure regarding Restraint Evaluation and Utilization Guidelines as well as the Physical Restraint Review Procedures.</p> <p>All staff were educated on 2/11/16 of guidelines and procedure in regards to creating, revising, and updating care plans.</p> <p>All residents have potential to be affected.</p> <p>2. Upon admission and ongoing throughout a resident's stay; including change of conditions, quarterly reviews, and annual reviews; structured individual programming and interventions will be developed based on each resident's history and assessed needs and preferences. The individual programming will address their social, emotional, physical, and cognitive functioning needs. If all other attempts are made and documented that they are unsuccessful and if it is deemed necessary that a resident requires a physical restraint the following will occur: a) Resident will properly be assessed for the safe use of a physical restraint with the use of a restraint assessment. b) Resident's family will be notified of need for a physical restraint and written/verbal consent will be obtained and documented. c) A Physician's order will be obtained and documented. d) Staff will be educated regarding the safe and proper use of a restraint. e) Resident's care plan will be updated with information regarding the use of a restraint. f) Weekly documentation will occur</p>	

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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>*At 11:45 a.m. the food arrived from the main kitchen.</p> <p>*At 11:48 a.m. CNA G wheeled resident 9 into the dining room.</p> <p>-She was placed with her back against the empty food cart where she started to yell and sing.</p> <p>-Other residents shook their heads. One said "oh god" as she shook her head.</p> <p>-Resident 9 was then wheeled to a table with one other resident and the resident's husband.</p> <p>-Her food was immediately placed in front of her and her utensils set out and she started feeding herself.</p> <p>*At 11:53 a.m.:</p> <p>-Resident 9 had consumed her meal and started yelling and throwing glasses and utensils.</p> <p>-CNA G moved resident 9 from the table out into the hallway.</p> <p>-She was placed with the back of the wheelchair against the wall halfway down the hallway where she continued to loudly sing.</p> <p>Surveyor: 35237</p> <p>Interview of registered nurse (RN) A and observation of resident 9 in the ACU on 2/2/16 at 12:15 p.m. revealed resident 9:</p> <p>*Was sitting alone in the living room area at the end of the hall in her wheelchair in front of the television with a seat belt fastened around her waist.</p> <p>*She was loudly yelling out repeated phrases.</p> <p>*RN A stated resident 9 frequently yelled out like that.</p> <p>*She was in the living room area instead of the dining room due to disrupting other residents at meal time.</p> <p>*Nursing staff were busy in the dining room at that time.</p>	F 309	<p>regarding purpose of restraint, resident's response to restraint, and frequency of release of restraint.</p> <p>Upon admission, an initial comprehensive care plan will be created and completed for each resident with the resident or the resident's family or legal representative, as well as the interdisciplinary team. The care plan will be reviewed, revised, and updated in correlation with each assessment and any significant changes to reflect their current needs on an ongoing basis, if appropriate.</p> <p>3. The Interim DNS or her designee will monitor activity participation to ensure that the individual programming meets the resident's needs. The Interim Director of Nursing or her designee will also monitor the 1:1 documentation to ensure that the 1:1's are getting done for residents who do not participate in one or more group activities a day. These audits will be conducted once a week for 12 weeks.</p> <p>Proper use of restraints will be monitored by Interim Director of Nursing or her designee. Restraints will be monitored on a daily basis for 12 weeks. Restraint audits will be conducted once a week for 12 weeks.</p> <p>The Interim DNS or her designee will monitor compliance of creating, revising, and updating care plans to reflect each resident's current needs. Audits will be completed each week for 12 weeks. Ongoing monitoring will be done with the quarterly reviews of the residents or any significant change of condition of each resident.</p> <p>Results of these audits will be presented by the Interim Director of Nursing to the monthly QAPI committee for review and recommendation.</p> <p><i>Quarterly SW/SB/EL</i></p> <p><i>*3/24/16</i></p> <p><i>SW/SB/EL</i></p>		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 Surveyor: 36413 Interview on 2/3/16 at 8:20 a.m. with the director of ACU in the living room area revealed: *Meal times for resident 9 would be earlier or later than scheduled meals depending on her behavior and staffing. -She would eat by herself for most of the meal. *When resident 9 was admitted on 9/25/15 she was more mobile and less behaviors. *Activities were schedule twice daily in ACU but were not always offered depending on staffing. *Resident 9's wheelchair had been changed and she was unaware why now had a seat belt.</p> <p>Observation on 2/3/16 during the above interview revealed another resident brought resident 9 in her wheelchair back to the living area and shut the door. She stated she was being too loud. After the other resident left the room, resident 9 began yelling out.</p> <p>Interview with CNA J on 2/3/16 at 8:30 a.m. revealed: *Resident care plans were kept at the nursing station outside of the ACU. *She did not have time to read the care plans and she did not review them often. *She was aware of resident 9's disruptive behaviors and felt she would have benefited from additional activiities or interventions.</p> <p>Inteviw on 2/3/26 at 8:50 a.m. with the director of nursing revealed: *Resident 9 had disruptive behaviors and she confirmed her dining experience was different from other residents. *She agreed resident 9 would have required a more individualized approach related to her behaviors, dining and activities.</p>	F 309			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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>*She confirmed her care plan did not address her individual needs.</p> <p>*She agreed her activities should have been individualized.</p> <p>Interview on 2/3/16 at 10:30 a.m. with social services designee B revealed:</p> <p>*Social services did not provide any services in the ACU except serving on a monthly review committee that reviewed medication and behaviors.</p> <p>*She would have expected individual care plans to reflect behaviors that were distressing to others.</p> <p>*She felt the residents physical needs were being met for the ACU residents, but activities were not. That was due to staffing being pulled to other units.</p> <p>Observation on 2/3/16 at 10:45 a.m. revealed resident 9 was in her room and no activities were going on in the ACU area. Some residents had gone to exercise outside the ACU.</p> <p>Surveyor: 35237</p> <p>Interview on 2/3/16 at 11:40 a.m. with the activity director revealed:</p> <p>*She did not participate or schedule any activities in the ACU, only the other units of the building.</p> <p>*The ACU staff were responsible for the activities in that unit.</p> <p>*Only a few residents from the ACU came out of the unit to attend activities.</p> <p>*Resident 9 did not come out of the ACU for activities.</p> <p>*She felt resident 9 did calm down and have less behaviors and yelling when someone had one-on-one interaction with her.</p> <p>*She should have had more individualized</p>	F 309		

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>
---	---

(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 activities and therapeutic programming due to her behaviors. *All residents should have had their activities and interventions on their care plan.</p> <p>Surveyor: 36413 Review of resident 9's January 2016 daily recreation participation record for activities revealed: *The daily activities were recorded, but there was no signature of who recorded the activity. *For independent activities one to one activities were documented 28 times and visiting was documented three times. -There was no specific amount of time documented or who completed the activity with the resident. *On January 12, 13, 14, and 15 the resident was documented as participating in Courtyard activity. -Interview on 2/3/16 at 10:30 a.m. with the DON revealed there was not Courtyard activity in the winter months.</p> <p>Review of resident 9's 10/7/15 care plan revealed: *There was no mention of her dining at different times than the other residents or how they were to address her behaviors during dining. *The only mention of activities was that she enjoyed snack and chat and listening to the news on TV. *It did address her history of wandering, physical and verbal behaviors, and excessive noise while residing in the ACU. Interventions for that area included: -Please tell me what you are going to do before you begin. -Speak to me unhurriedly and in a calm visit. -Staff to provide emotional support/reassurance</p>	F 309		
-------	--	-------	--	--

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 as warranted.</p> <ul style="list-style-type: none"> <li>-Staff to attempt cares later or with different staff if rejection occurs.</li> <li>-Staff to provide reminders or cueing as warranted.</li> <li>-Staff to redirect if wandering near an exit.</li> <li>-There were no specific activities or interventions to address her disruptive behaviors.</li> </ul> <p>Review of the January 2009 Golden Living Admission/Discharge Criteria revealed:</p> <ul style="list-style-type: none"> <li>*The resident must not be harmful to self or others.</li> <li>*The degree of nursing care needed must not outweigh the opportunity of the resident's benefit from the daily structured program.</li> </ul> <p>Review of the provider's 1/21/16 (review) Physical Restraint revealed:</p> <ul style="list-style-type: none"> <li>*Review of the medical record for documentation evidencing that alternatives were attempted prior to physical restraint use.</li> <li>*Ensure that the restraint assessment was completed and documented.</li> <li>*The chart would include physician orders for restraint use.</li> <li>*Ensure consent had been completed and signed by responsible party.</li> <li>*Care plan would reflect restraint use.</li> <li>*Document in nurses notes weekly the reason for restraint use.</li> </ul> <p>Review of the provider's 1/14/16 Guides for Caregiver Interaction with Dementia policy revealed:</p> <ul style="list-style-type: none"> <li>*Resident anxiety was decreased with optimal choices. Loss of control increased agitation.</li> <li>*Plan exercise each day to keep the resident active and ready for sleep at night.</li> </ul>	F 309			

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

PRINTED: 02/18/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/03/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>		
(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 24 *Staff must change their thinking from trying to control behavior to understanding and changing the reason behind the behavior. *Focus on abilities not limitations.	F 309			

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

ORIGINAL

PRINTED: 02/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>
---	---

(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	<p><i>*Addendums noted with asterisk per 2/29/16 per telephone with facility administrator.</i></p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/9/16. Golden LivingCenter - Groton was found not 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 upon correction of the deficiency identified at K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 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>	
K 069 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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 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 (exhaust system not functioning correctly). Findings include:</p> <p>1. Observation at 2:15 p.m. on 2/9/16 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 duct. The pressure was great enough to pull the grease baffles up into the hood duct. That created a fire safety issue as grease laden vapors were then capable of bypassing the grease baffles and</p>	K 069	<p>K069 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>1. The grease baffles will be secured into their frame. By securing the grease baffles to their frame, it will prevent them from moving. This will be completed by March 4<sup>th</sup>, 2016.</p> <p>All residents and staff have potential to be affected.</p> <p>2. Provider will ensure the commercial kitchen hood will be continuously maintained in reliable operating condition in accordance with the NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations.</p> <p>3. The Maintenance Director or his designee will audit through his preventative maintenance program that the lights work, he will check for grease and lint, he will check the baffles for stability and non-movement, he will ensure all caps are in place and that they are functioning as they are supposed to be.</p> <p>Results of these audits will be presented by the Maintenance Director to the monthly QAPI committee for review and recommendation.</p> <p>4. Substantial compliance will be in place by March 24, 2016.</p> <p><i>These audits will be conducted once a week for 12 weeks. ql</i></p>	<i>3/24/16</i> <i>LF/SDP/STH/L</i>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Executive Director</i>	(X6) DATE <i>2/25/16</i>
---	------------------------------------	-----------------------------

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: 02/16/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435048</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 NORTH SECOND STREET GROTON, SD 57445</b>	
(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>enter into the kitchen duct through the open space where the baffle void was located.</p> <p>Interview with the maintenance director at the time of the observation confirmed that condition. He indicated he had installed a new exhaust fan within the last month for the commercial kitchen ventilation system. He was aware the exhaust fan was capable of pulling the grease baffles and had tried to use metal clips to hold them in place.</p> <p>This deficiency has the capability of affecting one of four smoke compartments.</p>	K 069		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>
---	--

(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	<p><b>Compliance/Noncompliance Statement</b></p> <p>Surveyor: 34030 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/1/16 through 2/3/16 and on 2/9/16. Golden LivingCenter - Groton was found not in compliance with the following requirements: S206, S210, S236, and S253.</p>	S 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> <p><i>* Addendums noted with an asterisk per 3/17/16 per email with facility administrator.</i></p>	
S 206	<p><b>44:73:04:05 Personnel Training</b></p> <p>The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects:                      (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff;                      (2) Emergency procedures and preparedness;                      (3) Infection control and prevention;                      (4) Accident prevention and safety procedures;                      (5) Proper use of restraints;                      (6) Resident rights;                      (7) Confidentiality of resident information;                      (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;                      (9) Care of residents with unique needs;                      (10) Dining assistance, nutritional risks, and hydration needs of residents; and                      (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment.</p> <p>Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.</p>	S 206	<p>S 206 Personnel Training <i>SW/SDDOH/EL</i></p> <p>1. All staff were educated on 2/11/16 of policy and procedure regarding Restraint Evaluation and Utilization Guidelines as well as the Physical Restraint Review Procedures.</p> <p>All personnel and staff have the potential to be affected.</p> <p>2. Education will be provided annually on all of the following:                      a) Fire Prevention and Response                      b) Emergency Procedures &amp; Preparedness                      c) Infection Control and Prevention                      d) Accident Prevention and Safety Procedures                      e) Proper Use of Restraints                      f) Resident Rights                      g) Confidentiality of Resident Information                      h) Incidents and Diseases Subject to Mandatory Reporting and the Facility's Reporting Mechanisms                      i) Care of Residents with Unique Needs                      j) Dining Assistance, Nutritional Risks, and Hydration Needs of Residents                      k) Abuse, Neglect, Misappropriation of Resident Property and Funds, and Mistreatment.</p> <p>Personnel Education will not cease at subjects</p>	

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

*[Signature]*  
STATE FORM

6899

MYOK11

TITLE

*Executive Director*  
  
 SD DOH LSC

(X6) DATE

*2/25/16*

If continuation sheet 1 of 11

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>		
(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 206	Continued From page 1  Additional personnel education shall be based on facility identified needs.  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 34030 Based on interview and record review, the provider failed to ensure required yearly staff in-service on restraints was offered to their employees. Findings include:  1. Review of the provider's list of staff training done in the last year revealed: *A list of in-house training that had been completed. *Missing from the list were the required in-services on fire drills; dining assistance, nutrition, and hydration; and confidentiality. *Further review revealed fire drills had been covered by the maintenance department and dining assistance, nutrition, and hydration were taught by the dietary department. Confidentiality was a mandatory online course. *No required course on restraints had been found.  Interview on 2/3/16 at 11:15 a.m. with the director of nursing regarding the required in-services revealed: *The course for restraints was online but not made mandatory. Therefore none of the staff had completed it. *She agreed it should have been mandatory for all staff. *No policy for this existed.	S 206	listed above. Additional personnel education will be based on facility identified needs as appropriate. 3. Administrator will audit the education schedule for planned education throughout the year to ensure all subjects that are listed above will be covered. This audit will be conducted by March 4 <sup>th</sup> , 2016. Ongoing monitoring will be done after each all staff training monthly to ensure the planned education was delivered to all staff.  Results of this audit will be presented by the Administrator to the monthly QAPI committee for review and recommendation.   *3/24/16 SW/SDDO/HKL	
S 210	44:73:04:06 Employee Health Program	S 210		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>
---	--

(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	<p>Continued From page 2</p> <p>The facility shall have an employee health program for the protection of the residents. All personnel shall 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. Any 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 physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on record review and interview, the provider failed to ensure three of five sampled employees (B, C, and D) had a health evaluation completed within fourteen days of being hired. Findings include:</p> <p>1. Review of the following employees' personnel records revealed the following hired dates: *Employee B 10/14/15. *Employee C 12/1/15. *Employee D 11/5/15. *The above employees files had a health evaluation reviewed and signed by a health care professional on 12/30/15 to determine the employees were free of communicable diseases. -That date had been past fourteen days of their</p>	S 210	<p>S 210 Employee Health Program</p> <p>1. The three employees files had a health evaluation reviewed and signed by a health care professional on 12/30/15 that determined the employees were free of communicable diseases. There is no way to go back and have the three employees health evaluations signed within 14 days.</p> <p>Education was given to the staff member responsible for the General Orientation of the expectations that need to be met on all new staff members.</p> <p>All personnel and staff have the potential to be affected.</p> <p>2. All personnel will be evaluated by a licensed health professional freeing them from reportable communicable diseases which may pose a threat to others before or at hire or within 14 days of hire which will include an assessment of previous vaccinations and tuberculin skin tests. Shall an employee be subject to a communicable disease which may pose a threat, they may not return to work until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage.</p> <p>3. Audits will be performed by the General Orientation Leader on all personnel files or her designee to ensure that all personnel have a health evaluation reviewed and signed by a health care professional in their file as well as tuberculin skin tests. This audit will be conducted by March 4<sup>th</sup>, 2016 on all personnel. Ongoing monitoring will be done with each new hire by the General Orientation Leader or her designee.</p> <p>Results of these audits will be presented by the General Orientation Leader to the monthly QAPI committee for review and recommendation.</p> <p> *SN/SDDO/HCL</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/09/2016
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 N 2ND ST GROTON, SD 57445
--	--

(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 3 hired dates.  Interview on 2/3/16 at 11:55 a.m. with the administrator revealed: *She confirmed employees B, C, and D's health evaluations had been completed past fourteen days of them being hired to determine they were free of communicable diseases. *She was aware it should have been done in the fourteen days after having been hired per the regulations. *Her expectation was to follow the regulation for health evaluations.	S 210	<p>[REDACTED] *SN/SDDOH/EL</p> <p>Employee B will receive a two-step method of tuberculin skin test to establish a base-line. Employees C &amp; D no longer work for our company. <i>al</i></p> <p>S 236 Tuberculin Screening Requirements</p> <p>1. The three employees files that were referenced showed to have no documentation of tuberculin screening done. [REDACTED] *SN/SDDOH/EL</p> <p>[REDACTED] There is no way to go back and have the three employees have this completed within the fourteen days of being hired.</p> <p>Education was given to the staff member responsible for the General Orientation of the expectations that need to be met on all new staff members.</p> <p>All personnel and staff have the potential to be affected.</p> <p>2. All personnel hired will receive the two-step method of tuberculin skin test within 14 days of employment unless the personnel can provide documentation of tuberculin skin tests completed within the last 12 months prior to employment or if documentation is provided of a previous positive reaction to either test. If a positive reaction is determined will have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease.</p> <p>3. Audits will be performed by the General Orientation Leader on all personnel files or her designee to ensure that all personnel have had a tuberculin skin test within 14 days of hire. This audit will be conducted by March 4<sup>th</sup>, 2016 on all personnel. Ongoing monitoring will be done with each new hire by the General Orientation Leader</p>	*3/24/16 *SN/SDDOH/EL
S 236	44:73:04:12(1) Tuberculin Screening Requirements  Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new	S 236	<p>Education was given to the staff member responsible for the General Orientation of the expectations that need to be met on all new staff members.</p> <p>All personnel and staff have the potential to be affected.</p> <p>2. All personnel hired will receive the two-step method of tuberculin skin test within 14 days of employment unless the personnel can provide documentation of tuberculin skin tests completed within the last 12 months prior to employment or if documentation is provided of a previous positive reaction to either test. If a positive reaction is determined will have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease.</p> <p>3. Audits will be performed by the General Orientation Leader on all personnel files or her designee to ensure that all personnel have had a tuberculin skin test within 14 days of hire. This audit will be conducted by March 4<sup>th</sup>, 2016 on all personnel. Ongoing monitoring will be done with each new hire by the General Orientation Leader</p>	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>
---	--

(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 236	<p>Continued From page 4</p> <p>healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237</p> <p>Based on record review and interview, the provider failed to ensure three of five sampled employees (B, C, and D) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include:</p> <ol style="list-style-type: none"> <li>Review of employee B's personnel file revealed: *She was hired on 10/14/15. *Her first TB skin test had been completed on 10/15/15. *There was no record a second TB skin test had been completed.</li> <li>Review of employee C's personnel file revealed: *She was hired on 12/1/15. *There was no record of a TB skin test or screening.</li> <li>Review of employee D's personnel file revealed: *She was hired on 11/5/15. *There was no record of a TB skin test or screening.</li> <li>Interview on 2/3/16 at 11:15 a.m. with the business office manager revealed: *She had not known why those above employees had not been given their TB skin tests in a timely</li> </ol>	S 236	<p>or her designee.</p> <p>Results of these audits will be presented by the General Orientation Leader to the monthly QAPI committee for review and recommendation.</p> <p> *SW/SDDOH/EL</p>	<p>*3/24/16 SW/SDDOH/EL</p>

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/09/2016
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 N 2ND ST GROTON, SD 57445
--	--

(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 236	Continued From page 5  manner. *The nursing staff were responsible for the employees TB skin tests to have been given in a timely manner.  Interview on 2/3/16 at 11:55 a.m. with the administrator regarding the TB screenings for employees B, C, and D revealed: *She agreed the TB skin tests had not been given within fourteen days of employment and should have been. *Those TB skin tests had not followed the state guidelines for TB screenings for new employees. *Her expectation was to follow the state regulation for TB screenings.	S 236		
S 253	44:73:04:14 Memory Care Units  Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family; (5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety	S 253	S253 Memory Care Units  1. Resident #9's Individual Programming was reviewed on 2/4/16. One on one activities were put into place effective 2/23/16 after the Administrator, the Interim Director of Nursing, the Social Services Director, the Qualified Activity Director, the Alzheimer's Care Director, and the Dietary Services Manager met on 2/19/16 to review the policies and procedures about ensuring the needs of Resident #9 as well as ensuring the residents as a group as a whole are met.  All staff were educated on 2/11/16 of policy and procedure regarding the guidelines for Caregiver Interaction with Dementia.  The Alzheimer's Care Director and the Qualified Activity Director were assigned training as well, on the Learning Center called ALZ Therapeutic Activity Programming for Persons with Dementia. This training was completed by both staff members before 2/19/16.  The Administrator, the Interim Director of Nursing, the Social Services Director, the Qualified Activity Director, the Alzheimer's Care Director, and the Dietary Services Manager met on 2/19/16 to review the policies and procedures about ensuring the needs of individuals as well as	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10626	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  02/09/2016
--	---	---	--

NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER - GROTON	STREET ADDRESS, CITY, STATE, ZIP CODE 1106 N 2ND ST GROTON, SD 57445
--	--

(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 253	<p>Continued From page 6</p> <p>Code, 2012 edition; and (6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265</p> <p>Surveyor: 35237 Based on observation, record review, interview, and policy review, the provider failed to ensure one of three sampled residents (9) who resided in the Alzheimer's Care Unit (ACU) received therapeutic programming (any purposeful activity that fosters social, emotional, physical, cognitive, and mental well-being). Findings include:</p> <p>Surveyor: 33265 1. Observation on 2/1/16 at 5:30 p.m. in the ACU revealed: *Eleven of the twelve residents were in the dining room and the television was on. *The twelfth resident (9) was in her bed with her eyes closed.</p> <p>Observation on 2/2/16 from 8:00 a.m. through 9:25 a.m. in the secured unit revealed: *At 8:00 a.m. in the dining room you could hear resident 9 yelling from down the hall. *At 8:30 a.m. resident 9 was seen in the living room area at the opposite end of the hall from the dining room. -She was in her wheelchair in front of a bookcase. -There was a seatbelt fastened around her in the</p>	S 253	<p>the group as a whole are met.</p> <p>All residents have potential to be affected. Interdisciplinary Team will identify residents who could benefit from personalized 1:1 programing based on their group participation.</p> <p>2. Upon admission and ongoing throughout a resident's stay, including change of conditions, quarterly reviews, and annual reviews; structured individual programming and interventions will be developed based on each resident's history and assessed needs and preferences. The individual programming will address their social, emotional, physical, and cognitive functioning needs.</p> <p>3. The Interim DNS or her designee will monitor activity participation to ensure that the individual programming meets the resident's needs. The Interim Director of Nursing or her designee will also monitor the 1:1 documentation to ensure that the 1:1's are getting done for residents who do not participate in one or more group activities a day. These audits will be conducted once a week for 12 weeks.</p> <p>Results of these audits will be presented by the Interim Director of Nursing to the monthly QAPI committee for review and recommendation.</p>	<p>*3/24/16 SW/SDDO/H/EL</p>
-------	---	-------	---	----------------------------------

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>
---	--

(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 253	<p>Continued From page 7</p> <p>wheelchair. -The television was on. -She was bending over reaching for books on the second shelf of the bookcase and throwing the books as far as she could all over the room. *At 9:25 a.m. staff members noticed resident 9 was pulling the books off the shelf in the living room and she was moved to her room. -The maintenance director started picking up the books and items thrown about the living room. -He stated resident 9 had not done this before.</p> <p>Surveyor: 35237 Interview of registered nurse (RN) A and observation of resident 9 in the ACU on 2/2/16 at 12:15 p.m. revealed: *She was sitting alone in the living room area at the end of the hall in her wheelchair in front of the television and was loudly yelling out repeated phrases. *She stated the resident frequently yelled out like that and was in the lounge area instead of the dining room due to disrupting other residents at meal time. *Nursing staff were busy in the dining room at that time.</p> <p>Observation and interview on 2/3/16 at 8:00 a.m. with resident 9 revealed she: *Was sitting alone in her room in her wheelchair with the radio on. *Was able to answer questions when asked. *Had a loud voice and repeated statements frequently. *Appeared to calm down when talking one-on-one. *Clapped her hands repeatedly and had backed her wheelchair up against a wall.</p> <p>Review of the large activity calendar in the dining</p>	S 253		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>		
(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 253	<p>Continued From page 8</p> <p>room for the ACU revealed: *There was only one specific activity listed for each day. On Monday through Friday that activity was scheduled for 2:00 p.m. or 3:00 p.m. *On Saturday and Sunday a specific time for the activity was not listed. *Activities on the calendar included: -Puzzles. -Sensory box. -Coloring. -Expand your mind. -Arts and crafts. -Animal fit kit. -Art fit kit. *Exercise was daily from 10:45 a.m. through 11:00 a.m. *Snack and chat was daily at 3:00 p.m. -That was scheduled for the same time as the one scheduled activity could occur at.</p> <p>Random observations on 2/1/16 through 2/3/16 revealed: *Exercises were conducted in the main lounge area of the facility outside of the ACU. *Only three residents from the ACU had attended those exercises on 2/3/16. *Resident 9 had not attended exercises or been involved in any therapeutic activities. -She sat in front of the TV or listened to the radio at times.</p> <p>Interview on 2/3/16 at 8:20 a.m. with the ACU director regarding resident 9 revealed: *She frequently yelled out and was disruptive to the other residents. *She sat in the living room often with the television on and liked to listen to the radio at times. *Sometimes they set out the jewelry box for her to go through.</p>	S 253		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>
---	--

(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 253	<p>Continued From page 9</p> <p>*The large activity calendar in the dining room was their scheduled activity calendar for the ACU residents.</p> <p>*She had been the ACU director for the last few months and denied having additional training for working in the unit.</p> <p>*There was typically only one CNA during the day, evening, and night working in the ACU. The nurse relieved that CNA for break times.</p> <p>*She worked daytime during week days in the ACU.</p> <p>*She agreed the resident required more individualized therapeutic programming due to her behaviors and cognition.</p> <p>Interview on 2/3/16 at 8:30 a.m. with CNA J in the ACU revealed:</p> <p>*She normally did not work in the ACU.</p> <p>*There was usually just one CNA on the unit and the ACU director during the week days.</p> <p>*The nurse was only on the unit when passing medications and to cover for the CNA to take breaks.</p> <p>*It was difficult to do therapeutic activities in the ACU when there was only one CNA.</p> <p>*Resident 9 should have had more one-to-one or other therapeutic activities to keep her busy.</p> <p>Interview on 2/3/16 at 11:40 a.m. with the activity director revealed:</p> <p>*She did not participate or schedule any activities in the ACU, only the other units of the building.</p> <p>*The ACU staff were responsible for the activities in that unit.</p> <p>*Only a few residents from the ACU came out of the unit to attend activities.</p> <p>*Resident 9 did not come out of the ACU for activities.</p> <p>*She felt resident 9 calmed down and had less behaviors and yelling when someone had</p>	S 253		
-------	--	-------	--	--

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10626</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/09/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - GROTON</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1106 N 2ND ST GROTON, SD 57445</b>		
(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 253	<p>Continued From page 10</p> <p>one-on-one interaction with her. -She should have had more individualized activities and therapuetic programming due to her behaviors. *All residents should have had their activities and interventions on their care plans.</p> <p>Review of resident 9's current care plan on 2/3/16 revealed there was no specific mention of her activities, therapeutic programming, or what interventions could have been utilized.</p> <p>Review of the provider's 2009 Recreation Services Guide: Individual Programming policy revealed: **Structured individual interventions will be developed based on each resident's history and assessed needs and preferences." **Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical, and cognitive functioning needs." **Examples of individualized activities might include any of the following:" -"Sensory stimulation of cognitive therapy." -"Social engagement." -"Spiritual support, nurturing." -"Creative, task-oriented acitvities." -"Support of self-directed activity."</p>	S 253		