

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435049</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>06/12/2014</b>
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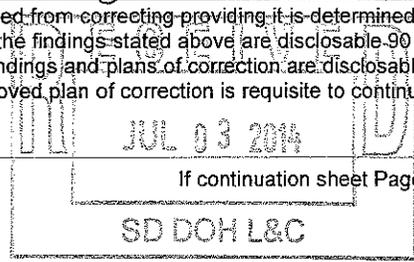
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>Surveyor: 22452 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 6/12/14. Areas surveyed included resident care issues and resident safety. Golden LivingCenter - Salem was found not in compliance with the following requirements: F225 and F281.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p>	F 225	<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. This applies to F225 and F281</p> <p>F225 Investigate/Report Allegations/Individuals</p> <ol style="list-style-type: none"> <li>1. A post fall investigation for resident two was completed on 6/9/14 by the Director of Nursing. A final report was sent to the Department of Health on 7/1/14 as a summary of the investigation outcomes.</li> <li>2. All residents have the potential to be affected.</li> <li>3. The Administrator, Director of Nursing Services and interdisciplinary team reviewed, revised as necessary the policy and procedure about appropriate reporting of resident events to required sources and maintaining a complete and accurate document of care and follow-up after an acute event that meets professional standards on 6-27-14. All staff were educated on the policy and procedure about appropriate reporting of resident events to required sources and maintaining a complete and accurate document of care and follow-up after an acute event that meets professional standards by 7/5/14.</li> </ol>	7-15-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jennifer Meyer</i>	TITLE Interim Executive Director	(X6) DATE 7-2-14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 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.



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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure one of one sampled resident (2) entrapment in a side rail was investigated and reported to the South Dakota Department of Health (SD DOH). Findings include:</p> <p>Review of resident 2's 6/19/14 care plan revealed: *Physical functioning deficit (lack of): -Bed mobility of two staff assistance. -Transfer with two staff assist. -Wheelchair used for mobility and pushed by staff. *Self care impairment: -Dressing and personal hygiene by one to two staff assistance. -Toileting with one staff assistance. *Range of motion limitations due to obesity and arthritis. *Impaired vision related to glaucoma. *At risk for falls related to use of an antianxiety and antidepressant medication. *Impaired communication due to impaired hearing.</p>	F 225	<p>4. The Director of Nursing Services or designee will audit up to a minimum of 4 verification of investigation reports if they exist to assure reporting and investigation policy has been followed weekly times 4 and monthly times 3. Results of the audits will be reported to the monthly Quality Assurance and Process Improvement committee for further review and recommendations.</p>	
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F 225	<p>Continued From page 2</p> <p>*Dementia (memory loss).</p> <p>Review of resident 2's 6/7/14 at 11:30 p.m. progress notes revealed:</p> <p>**Call light on. Staff entered room to answer light, resident found on floor next to bed with chin caught between mattress and side rail."</p> <p>**Bruising noted to left side of jaw and right side of abdomen."</p> <p>**Certified nursing assistant braced resident to prevent further harm."</p> <p>**911 called. First responders arrived and chin freed from side rails. Resident assessed and lifted from floor by emergency medical staff."</p> <p>**Ice pack applied. Will continue to monitor."</p> <p>Review of resident 2's facsimile sent to the physician with the incorrect date of 6/6/14 revealed:</p> <p>**Was found in room lying next to bed with chin hung up inside rail."</p> <p>**Staff braced resident and 911 called. Able to free chin from rail."</p> <p>**Only superficial injuries noted. She was talking and moving all extremities (arms and legs)."</p> <p>**Bruising noted to left jaw."</p> <p>Interview on 6/12/14 at 10:45 a.m. with resident 2 revealed:</p> <p>*She got her neck caught in the side rail, because she was too close to the edge of the bed.</p> <p>*The staff usually did not position her so closely to the edge of the bed, and usually had her more positioned more in the middle of the bed.</p> <p>*She was glad she had her call light to call for assistance.</p> <p>Interview on 6/12/14 at 11:00 a.m. with the director of nursing regarding resident 2 revealed:</p>	F 225		
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F 225	Continued From page 3 *They had not reported the side rail entrapment to the SD DOH, because she had not been injured. *They had removed both the side rails after the incident, because they were a hazard to her. *She had used the side rails as a positioning device and to assist the staff when they repositioned her. *The staff had felt she had scooted to the edge of the bed. *The facsimile sent to the physician on 6/6/14 should have been dated 6/7/14. *They did not have physician's orders since the assessment had determined the use of the side rails were not a restraint.	F 225	F 281 Services provided meet professional standards	7-15-14
F 281 SS=D	<b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 22452 Based on record review and interview, the provider failed to ensure nurses followed-up and documented thoroughly after: *An acute entrapment in a side rail for one of one sampled resident (2). *The discovery of one of one sampled resident (2) with a call light cord wrapped around her neck. Findings include:  1. Review of resident 2's 6/7/14 at 11:30 p.m. progress notes revealed: **Call light on. Staff entered room to answer light, resident found on floor next to bed with chin	F 281	1. No corrective action to be taken regarding a follow up clinical assessment for resident two. A shorter call cord was placed in resident 2's room on 6/12/14.  2. All residents have the potential to be affected.  3. The Administrator, Director of Nursing Services and interdisciplinary team reviewed and revised as necessary the policy and procedure about appropriate reporting of resident events to required sources and maintaining a complete and accurate document of care and follow-up after an acute event that meets professional standards on 6-27-14. All staff were educated on the policy and procedure about appropriate reporting of resident events to required sources and maintaining a complete and accurate document of care and follow-up after an acute event that meets professional standards by 7/5/14. The Director of Nursing Services or designee will audit up to four falls/change of condition to assure appropriate follow up and documentation are completed per policy weekly times 4 and monthly times 3. Results of the audits will be reported to the monthly Quality Assurance and Process Improvement committee for further review and recommendations.	

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

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F 281	<p>Continued From page 4</p> <p>caught between mattress and side rail." **"Bruising noted to left side of jaw and right side of abdomen." **"Certified nursing assistant braced resident to prevent further harm." **"911 called. First responders arrived and chin freed from side rails. Resident assessed and lifted from floor by emergency medical staff." **"Ice pack applied. Will continue to monitor."</p> <p>Continued review of resident 2's progress notes revealed the next documentation was not until twenty-four hours later on 6/8/14 at 11:56 p.m.: **"Resident noted to have moderate amount of dark purple bruising noted to the left and right side of her throat and jaw line." **"Resident states she has mild pain to area. Pain medication denied and also denies ice pack at this time and stated she was fine."</p> <p>2. Review of resident 2's 6/11/14 at 2:04 p.m. progress notes revealed: **"Certified nursing assistant (CNA) told nurse she walked into resident's room and found the call light cord wrapped around resident's neck with her hands on the cord." **"CNA asked resident why she was doing that and she replied she did not know." *There was no further documentation related to the incident or that the physician and family had been informed..</p> <p>3. Interview on 6/12/14 at 2:30 p.m. with the director of nursing regarding resident 2 revealed: *She let the nurses use their professional judgement and critical thinking related to documentation after an acute episode. *It was not necessary to monitor her vital signs (blood pressure, pulse, and respirations) as she</p>	F 281		

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F 281	Continued From page 5 had not had a fall with a head injury. *After the 6/11/14 incident they had talked about just making sure she had her call light, and it was positioned so she could not pull it out to full length. She had a long call light cord. They had failed to document that or update her care plan. *She knew the nurses had checked on her between 6/7/14 at 11:30 p.m. and 6/8/14 at 11:56 p.m. but had failed to document that. *They did not have a policy for documentation for an acute incident or when vital signs should have been obtained.	F 281		