

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>03/19/2015</b>
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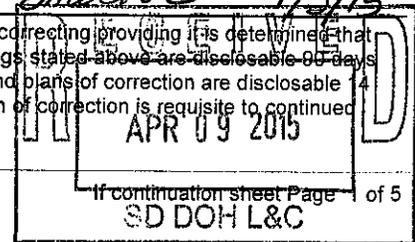
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - SALEM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>500 COLONIAL DRIVE SALEM, SD 57058</b>
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F 000	<p><i>Addendums noted with an asterisk per 4/15/15 telephone to facility DON. JTS/DOH/L&amp;C</i></p> <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 32331 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 3/19/15. Areas surveyed included resident care issues, infection control, and staffing. Golden LivingCenter - Salem was found not in compliance with the following requirement: F279.</p>	F 000	<p><b>STATEMENT OF COMPLIANCE:</b></p> <p>The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on March 19, 2015. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of April 11, 2015. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.</p>	
F 279 SS=D	<p><b>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview, record review, and the</p>	F 279		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Ruonnica J Smith</i>	TITLE  <i>Executive Director</i>	(X6) DATE  <i>4/3/15</i>
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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.



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

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F 279	<p>Continued From page 1</p> <p>provider's January 2012 Clinical Health Status document review, the provider failed to develop a thorough temporary care plan regarding pressure ulcers for one of two sampled residents (3) with pressure ulcers. Findings include:</p> <p>1. Interview on 3/19/15 at 9:15 a.m. with resident 3 in his room while seated in a wheelchair revealed:</p> <ul style="list-style-type: none"> <li>*He had pressure ulcers (injuries to skin and underlying tissue) on his feet.</li> <li>*He had a history of skin breakdown on his feet.</li> <li>*His left foot's skin "was worse than his right foot."</li> <li>*He had been admitted on 3/1/15 with open areas on his feet.</li> <li>*He needed assistance with all transfers (moving from one place to another).</li> </ul> <p>Review of resident 3's medical record revealed:</p> <ul style="list-style-type: none"> <li>*He was admitted on 3/11/15.</li> <li>*He had diagnoses that had included ulcer (injury to the skin and underlying tissue) of the foot, diabetes, major depressive disorder, malaise (a feeling of discomfort), and fatigue (tired).</li> <li>*A physician's order dated 3/11/15 "Betadine [helps reduce bacteria that can cause skin infections] Solution 10% [percent] (Providone-Iodine) Apply to plantar L [left] foot/left heel topically [on the surface of the skin] two times a day related to ULCER OF OTHER PART OF FOOT (707.15) [a diagnosis code]."</li> </ul> <p>Review of resident 3's 3/11/15 temporary care plan revealed:</p> <ul style="list-style-type: none"> <li>*There had been no documentation regarding his history of pressure ulcers.</li> <li>*There had been no documentation regarding his skin condition on admission or at current.</li> </ul>	F 279	<p>For Resident #3, pressure sore admission care plan added immediately when identified on March 19, 2015.</p> <p>Newly admitted residents who have not had a comprehensive care plan have the potential to be affected in a similar manner.</p> <p>All new admissions 30 days prior to survey on March 19, 2015 were reviewed with no additional concerns identified. <i>*by the Administrator and the DON JTS/DH/ME</i></p> <p>Directed in-service training will be completed 4/9/15 with Administrator, DON, IDT and nurses to review and revise or create as the policy and procedure about care plan process. The review will include findings cited in the deficiency as well as the care plan process including:</p> <ul style="list-style-type: none"> <li>• accurate and comprehensive assessments</li> </ul>		

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F 279	<p>Continued From page 2</p> <p>*There had been no goals or interventions put in place to heal the areas and to have prevented those areas from further breakdown.</p> <p>*There was no mention of the resident's pressure ulcers on that temporary care plan.</p> <p>Review of resident 3's 3/11/15 Braden scale (predicts pressure ulcer risk) revealed: *He was chairfast (must be assisted in and out of chair or wheelchair). *His mobility (ability to change and control body positions) was very limited. *His total score was eighteen that put him at risk for developing pressure ulcers.</p> <p>Review of resident 3's 3/11/15 and 3/16/15 Wound Evaluation Flow sheets revealed: *He had four pressure ulcers. *Those above areas were each at a stage II (partial thickness skin tissue loss) that included the: -Left heel. -Left plantar (sole of the foot) on the left side. -Right foot's big toe. -Right foot's little toe.</p> <p>Interview on 3/19/15 at 4:30 p.m. with registered nurse (RN) A and the director of nursing (DON) regarding resident 3's temporary care plan revealed: *RN A had completed his admission paperwork on 3/11/15. *RN A agreed his care plan needed to have reflected the altered skin status that included pressure ulcers. *RN A agreed he was at risk for pressure ulcers and had needed that information on the care plan. *RN A stated it had been his responsibility for</p>	F 279	<ul style="list-style-type: none"> <li>• timely collection of data</li> <li>• generating a problem list/CAAs</li> <li>• identifying goals and outcomes</li> <li>• determining approaches</li> <li>• review of timeframes</li> </ul> <p>Director of Nursing will review <sup>call</sup> new admissions weekly x4 and then monthly x 3 or until 100% compliance for 3 months that initial care plans were implemented and accurate. DON will report results of the audits monthly and they will be reviewed by the QAPI committee for further recommendations.</p> <p>*The interdisciplinary team (IDT) is responsible for the above bulleted care plan process and for creating, revising, or reviewing care plans. The wound nurse or the IDT is responsible for updating skin status from the skin assessments on the care plan.</p>	<p>4/11/15</p> <p>JTS/DON/MF</p>

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F 279	<p>Continued From page 3</p> <p>updating the care plan on admission and as needed as he had worked with wound care in the facility.</p> <p>*Both confirmed there was no documentation regarding goals and interventions available regarding his skin status and pressure ulcers for the staff.</p> <p>*Both agreed the care plan had not included any information regarding his skin on admission or at the current time.</p> <p>*Both agreed his care plan should have addressed his current and past history with pressure ulcers.</p> <p>*Both stated an Immediate Plan of Care Pressure Ulcer Risk form should have been completed and included with his temporary care plan.</p> <p>*That above form would have included:</p> <ul style="list-style-type: none"> <li>-The location of the pressure ulcers.</li> <li>-Interventions (what could have been done to help the resident).</li> <li>-Goal for the management of risk factors that contributed to pressure ulcer development.</li> </ul> <p>*Both confirmed his care plan was not specific to his needs regarding his altered skin condition.</p> <p>Interview and record review on 3/19/15 at 5:25 p.m. with the DON regarding resident 3's temporary care plan revealed:</p> <p>*She had been doing audits on care plans for new admissions.</p> <p>*Her last audit had been on 2/7/15.</p> <p>*She had planned to have done another audit in March.</p> <p>*He had been admitted on 3/11/15, and his pressure ulcers and skin had not been documented.</p> <p>*There was no specific care plan policy.</p> <p>Review of the provider's revised January 2012</p>	F 279			

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F 279	Continued From page 4 Clinical Health Status, section B, under skin conditions, revealed "If skin condition present, initiate IPOC [Immediate Plan of Care] and Weekly Skin Report."	F 279		