

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

ORIGINAL

PRINTED: 04/05/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/23/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><i>*Addendums noted with INITIAL COMMENTS on asterisk per 4/28/16 per email with facility administrator. SW/SPDOH/EL</i></p> <p>Surveyor: 34030 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/21/16 through 3/23/16. Golden LivingCenter - Arlington was found not in compliance with the following requirements: F176, F226, and F252.</p> <p>A complaint health survey for compliance with 42CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/21/16 through 3/23/16. Areas surveyed included resident neglect and dietary services. Golden LivingCenter Arlington was found not in compliance with the following requirements: F246 and F323.</p>	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on March 23, 2016. Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of May 12, 2016. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith and as the living center's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</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: 33265 Based on observation, interview, record review, and policy review, the provider failed to assess for capability and obtain physician's orders for the self-administration of nebulizer (breathing treatment) treatments for one of one sampled resident (8). Findings include: 1. Observation on 3/22/16 at 10:15 a.m. with</p>	F 176	<p>Resident # 8 has had a Self Administration of Medication Evaluation completed and has been deemed safe to self administer nebulizer after nurse set up. Resident has received education related to policy. Care plan has been reviewed and revised.</p> <p><i>*5/12/16 SW/SPDOH/EL</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Theresa DeB...</i>	TITLE <i>Interim Administrator</i>	(X6) DATE <i>4/8/16</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.

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F 176	<p>Continued From page 1</p> <p>licensed practical nurse A in resident 8's room revealed:</p> <ul style="list-style-type: none"> *The resident had a scheduled nebulizer treatment. *She completed assessment of the resident's oxygen saturation. *She set-up the medication for the resident. *She then placed the face mask on the resident and said she would be back in ten minutes. *She then left the room. *She returned in ten minutes and found the treatment was complete. *She shut off the machine, removed the face mask, and assessed the resident's oxygen saturation, and found it had not changed. *She stated that was her usual process for a nebulizer treatment. <p>Review of resident 8's complete medical record revealed:</p> <ul style="list-style-type: none"> *She had been admitted on 3/11/16. *She had a diagnosis of chronic obstructive pulmonary disease. *There was no documentation of an assessment or physician order for her to self-administer the nebulizer treatment. <p>Interview on 3/23/16 at 1:45 p.m. with the director of nursing regarding resident 8 revealed she agreed:</p> <ul style="list-style-type: none"> *The resident had not received an assessment nor a physician's order for self-administration of medications. *The nurse should have stayed with the resident during the nebulizer treatment. <p>Review of the provider's May 2012 Self-Administration of Medications policy revealed:</p>	F 176	<p>Residents residing in the facility who wish to self administer medications have the potential to be affected in a similar manner.</p> <p>Residents who wish to self administer medications have been identified and a Self Administration of Medication Evaluation has been completed and physician order is in place. Residents who have been deemed safe to self administer medications have been educated and are in compliance with the Self Administration of Medication policy. New residents admitted to the living center will be educated on the Self Administration of Medication policy upon admission.</p> <p>Nursing staff will be re-educated on the Self Administration of Medication policy, which includes Physician orders, Assessment and Care Planning.</p> <p>Director of nursing or designee will complete audits of all residents who wish to self administer medications weekly x4 then monthly x2 to ensure compliance with the policy and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>		

3/12/16

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F 176	Continued From page 2 *If the resident had indicated a desire to self-administer medications an assessment by the interdisciplinary team should have been completed. *A physician's order for self-administration of medications should have been requested if the resident demonstrated her ability to self-administer medications.	F 176	*we have a physician order for resident #8 to self administer medication. LPN recieved training on the self-administration of medications policy.		
F 226 SS=D	Review of the provider's undated Medication Administration Competency Checklist for Nebulizers revealed if the resident was to be left alone self-administration of medication (SAM) should have been in place. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to thoroughly investigate an incident for one of one resident (11) who reported missing money. Findings include: 1. Review of a 12/3/15 incident report sent to the South Dakota Department of Health (SD DOH) regarding resident 11 revealed: *She had reported having two \$50.00 bills, one \$20.00 bill, and a few one dollar bills in her purse,	F 226	The incident cited in the statement of deficiencies occurred on 12/15/15; the facility is unable to reconstruct an accurate and through investigation of this incident due to the time lapse. Residents residing in the facility have the potential to be affected in a similar manner. All staff will be reeducated on the Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation Policy Executive Director or Designee will audit all grievance/events that happened in the facility to ensure above policy is followed weekly for 4 weeks and then monthly for 2 months. The Executive Director and will bring results of audits to the monthly QAPI meeting for further review and recommendations.	*5/12/16 SW/SDDOH/EL	

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F 226	Continued From page 3 and they had gone missing. *Her daughter had been notified and was unsure how much money her mother had in her purse. *She had a Brief Interview of Mental Status (BIMS) score of 13 that meant her cognitive thinking was intact. *There had been no further interview with the resident to find out where she had gotten the money. *There had been no other documentation regarding who had been working with the resident in the past few days. *They had given her \$125.00 to make up for the lost money but would only reimburse her \$10.00 if it happened again. *There was no documentation of interviews conducted with staff. Interview on 3/23/16 at 1:30 p.m. with the director of nursing regarding the investigation of the missing money revealed they had not conducted interviews with staff. There was no further documentation of the investigation into the missing money. Review of the provider's 2/12/16 Preventing, Investigating, and Reporting Alleged Sexual Assault and Abuse Violation policy revealed: *The investigation should have included interviews with employees, visitors, and residents who might have had information regarding the incident. *Only factual information should have been documented. *The medical record should have been reviewed to determine the resident's past history and condition and the relevance to the incident.	F 226	*resident 11 has been reimbursed \$125. ⁰⁰ . This resident has set up a resident trust account and is encouraged to deposit money into that. SWISRDDOTHEL		
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246			

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F 246 SS=E	<p>Continued From page 4 OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and record review the provider failed to ensure assistance was provided to three of three sampled residents (2, 3, and 12) who needed assistance with eating. Findings include:</p> <p>1. Observation in the dining room on 3/21/16 from 5:50 p.m. through 6:20 p.m. revealed: *Three of the four residents (3, 12, and an unidentified resident) at one table had their food at 5:50 p.m. *Resident 2 did not get served until 6:01 p.m. *Staff had been sitting next to resident 2 but got up to assist another resident at a different table as soon as she had been served. *The unidentified staff member had not attempted to assist resident 3 or 12 while she had been sitting at the table. *No staff person was at the table assisting residents 2, 3, or 12.</p> <p>Interview on 3/21/16 at 6:05 p.m. with certified nursing assistant D revealed the pureed food for resident 2 had not been hot enough and had to be reheated before it was served.</p>	F 246	<p>Resident #2, 3 and 12 have staff assistance with eating.</p> <p>Residents residing in the facility that needs assistance with eating have the potential to be affected in a similar manner.</p> <p>The Director of Nursing and Interdisciplinary team have reviewed the Nursing Responsibilities at Meal Service policy</p> <p>All staff responsible for providing care and services for the residents will be reeducated on the Nursing Responsibilities at Meal Service policy</p> <p>Director of nursing or designee will complete audits of the dining experience 3 meals weekly x4 then monthly x2 to ensure residents are receiving the assistance required to eat and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	5/12/16

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F 246	Continued From page 5 Observation in the dining room on 3/22/16 from 11:45 a.m. through 12:05 p.m. revealed residents 2, 3, and 12 had been served their food but there was no staff at the table assisting those residents with eating. Review of resident 2's 2/26/16 Minimum Data Set (MDS) assessment she needed extensive assistance of one staff person to assist her with eating. Review of resident 3's 2/19/16 MDS assessment revealed he needed extensive assistance of one staff person to assist him with eating. Review of resident 12's 2/23/16 MDS assessment revealed she needed limited assistance of one staff person to assist her with eating. Interview on 3/23/16 at 1:00 p.m. with the director of nursing regarding the above observations revealed staff should have been assisting residents 2, 3, and 12 at meals with cueing and supervision. She was not sure why staff were not assisting them.	F 246		
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by:	F 252	The carpeting in the main lobby and dining room will be replaced. The Maintenance Director has taped the remaining windows that have a draft. The air conditioners will be placed in the windows soon and then this fall	

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F 252	Continued From page 6 Surveyor: 32335 Based on observation and interview, the provider failed to maintain carpeting in common use areas (dining room and hallways) in one of one building and windows in four of four residents' rooms (106, 107, 109, and 201.) Findings include: 1. Confidential group interview on 3/22/16 at 10:00 a.m. with six residents revealed sometimes the rooms were cold in the winter. The wind came through the windows. If a resident had told the staff then black tape would be placed around the window to keep out the wind. Observation and interview on 3/22/16 from 2:50 p.m. through 3:35 p.m. with the maintenance director revealed their were six resident rooms that had black tape covering the windows due to wind getting through. He was unable to list the room numbers. This surveyor had only found four windows on tour that had black tape covering the window frame. When a resident complained of the cold draft in their room he would put tape over the window. They had not looked into getting new windows. The carpet in the common area had visible stains and had seams that were showing and fraying. It could potentially be a trip hazard for residents. He agreed the carpet needed to be replaced. They had discussed carpeting with their corporate office, but no decisions had yet been made about replacing it.	F 252	the maintenance director will caulk all windows that have a draft after the A/Cs have been removed All residents residing in this facility have the potential to be affected in a similar manner The maintenance director has been educated on maintaining carpet and the plan to fix that drafts in the windows. Maintenance Director or Designee will complete audits monthly for 4 months to ensure the remaining carpet is in good condition, and that the windows are sealed properly. *After the audits are complete the maintenance director or designee will monitor the carpet and windows during the quarterly room inspections. Maintenance director or designee will report the findings to QUAPI. Resident #4 fall history has been reviewed by the Interdisciplinary team and the care plan reflects individualized interventions related to prevention of further falls.	5/12/16	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323			

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F 323	<p>Continued From page 7 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview, record review, and policy review, the provider failed to implement interventions to prevent falls for one of one sampled resident (4) who had multiple falls. Findings include:</p> <p>1. Review of resident 4's medical record revealed he had fallen on the following dates: *6/22/15 at 3:25 a.m. *8/9/15. *8/21/15 at 6:30 p.m. *8/28/15. *9/12/15. *10/14/15 at 5:00 a.m. *11/12/15 at 1:15 p.m. *11/14/15. *11/17/15 at 7:00 p.m. *11/18/15. *11/20/15. *12/21/15. *12/30/15. *1/19/16 at 08:45 a.m. *1/21/16 at 6:30 p.m. *2/4/16 at 5:00 a.m. *2/10/16 at 1:15 p.m. *3/9/16 at 8:15 a.m. and 9:45 a.m. *3/11/16 at 4:35 p.m. *All twenty of the above falls occurred when he was self-transferring himself.</p> <p>Review of resident 4's undated care plan</p>	F 323	<p>Residents residing in the facility who have fallen or have been identified at risk for falls have the potential to be affected in a similar manner. The Interdisciplinary team has completed a comprehensive review of the identified residents and has revised the care plan to reflect individualized interventions to prevent further falls.</p> <p></p> <p>Director of nursing or designee will complete audits of residents who have fallen each day during clinical start up to ensure review by the Interdisciplinary team and the care plan reflects individualized interventions related to prevention of further falls and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p>	
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SWMS/DCH/EL

**Nursing staff including 5/12/16 CNA's have been reeducated on the falls management guidelines. Staff will be reeducated on the call light policy to ensure the call lights are not being shut off without residents being assisted.*

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F 323	<p>Continued From page 8</p> <p>revealed he needed extensive to limited assistance from one staff person to go to the bathroom. He needed extensive assistance of one staff person to transfer from one place to another place. There was no scheduled intervention to check in on him, either so many times or within so many hours throughout the day to see if he needed staff assistance.</p> <p>Interview on 3/23/16 at 10:45 a.m. with resident 4 revealed:</p> <ul style="list-style-type: none"> *He would put his call light on for assistance. *Staff would come in, turn off the call light, state they would be right back, and then not return. *Staff did not check in on him on a regular basis. *If he needed assistance he had to call for it. *Throughout the day only one certified nursing assistant (CNA) would ask him to go for a walk. -Walking was one of his interventions for falls. *The other CNAs would not walk with him. <p>Review of resident 4's progress notes revealed there was no documentation the interdisciplinary team reviewed why he was self-transferring.</p> <p>Interview on 3/23/16 at 2:00 p.m. with the director of nursing regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *He would refuse to walk with staff according to the CNA documentation. -The only selections a CNA had to choose from was "refused, out of the facility, resident in the facility but not available." -There were no choices for sleeping or asked to come back later. *She knew he only walked with one of the CNAs. *She had not followed-up to see why he was not walking with the other CNAs. *The one CNA who did assist him refused to walk with him if he did not wear his leg brace. 	F 323		

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F 323	<p>Continued From page 9</p> <ul style="list-style-type: none"> *He did not wear the brace, because it caused him discomfort. *He also had swelling in his legs, so that could cause discomfort as well. *They had not attempted to replace the leg brace. *She had never monitored if other CNAs asked him to walk. *She was unaware CNAs would turn off the call light and not return to assist the resident. <p>Review of the provider's 10/21/15 Falls Management Guideline policy revealed residents at risk for falls should have had individualized interventions on the care plan.</p>	F 323		

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/23/16. Golden LivingCenter-Arlington was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Theresa DeB...* TITLE *Interim Administrator* (X6) DATE *4/8/16*

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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NAME OF PROVIDER OR SUPPLIER
GOLDEN LIVINGCENTER - ARLINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE
**120 CARE CENTER RD POST OFFICE BOX 280
ARLINGTON, SD 57212**

(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
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S 000

Compliance/Noncompliance Statement
** Addendum noted with call asterisk per 4/28/16 per email with facility administrator, SWISDOHTEL*
 Surveyor: 34030
 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/21/16 through 3/23/16. Golden LivingCenter - Arlington was found not in compliance with the following requirement: S206.

S 000

STATEMENT OF COMPLIANCE:
 The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted on March 23, 2016.

S 206

44:73:04:05 Personnel Training

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.

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.

S 206

Please accept this plan of correction as the living center's Credible Allegation of Compliance with the completion date of May 12, 2016.

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.

Current Certified Nursing Assistant who have not received formal orientation have been identified and will receive formal orientation by May 12, 2016

New Certified Nursing Assistants will receive formal orientation.

Staff has been reeducated of timeliness of completing required orientation to include the lift cleaning policy.

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

Theresa DeB...

TITLE

Interm...

(X6) DATE

APR 11 2016
SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/23/2016
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER RD POST OFFICE BOX 280 ARLINGTON, SD 57212
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 206	<p>Continued From page 1</p> <p>Additional personnel education shall be based on facility identified needs.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32335 Based on observation, interview, and record review, the provider failed to have a formal orientation program for their certified nursing assistants (CNA). Findings include:</p> <p>1. Observation on 3/22/16 at 9:00 a.m. of CNA B and CNA C revealed they had used a mechanical lift to transfer resident 3 from his wheelchair to his bed. He touched the handles of the lift while being transferred. Upon completion of the transfer CNA C removed the mechanical lift from the resident's room and took it into another resident's room. This surveyor had walked with her to and from the room where she had left the lift. She had not disinfected the lift after using it with resident 3.</p> <p>Interview with CNA C after the above observation revealed she only cleaned the lift when it was visibly dirty. CNA B interrupted and stated they cleaned the lift after each use. CNA C agreed she had not disinfected the lift after transferring resident 3.</p> <p>Interview and record review on 3/23/16 at 8:30 a.m. with the interim administrator revealed they had not completed the orientation program for new hires for at least the past four to six months.</p>	S 206	<p>Executive Director or designee will complete monthly audits x3 to ensure Certified Nursing Assistants have completed required orientation and will bring results of audits to the monthly QAPI meeting for further review and recommendations.</p> <p><i>*CNA B and CNA C have recieved orientation. SW/SDDO/H/EL</i></p>	5/12/16