

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

ORIGINAL

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</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 5/11/16 with facility administrator. NS/SDDOH/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 23059 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 - Bella Vista was found not in compliance with the following requirements: F371, F387, and F441.</p> <p>Surveyor: 26632 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/22/16 through 3/23/16. Areas surveyed included resident safety, infection control, and quality of care. Golden LivingCenter - Bella Vista was found in compliance.</p>	F 000	<p><b>STATEMENT OF COMPLIANCE:</b> 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.</p> <p><b>F371</b></p> <p>No residents were identified to have negative outcomes related to the food temps procurement.</p> <p>All residents are potentially at risk related to the compromised food procurement and proper food temperatures. <i>*5/12/16 NS/SDDOH/EL</i></p> <p>Dietary Services Manager and RD will review and revise policies and procedures related to taking food temperatures, hand hygiene and glove use.</p> <p>The Dietary Services Manager will provide education regarding</p>	
F 371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview, and policy review, the provider failed to ensure: *Two of two cooks (A and B) had taken food</p>	F 371		

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

*Debra McLaugh*

TITLE

*N/A*

(X6) DATE

*4/11/2016*

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.

APR 12 2016

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F 371	<p>Continued From page 1</p> <p>temperatures according to their policy for two of two meal services.</p> <p>*One of two cooks (A) had used gloves and washed hands according to their policy during one meal service. Findings include:</p> <p>1. Observation of the 3/21/16 supper meal revealed cook A:</p> <p>*Put on gloves and used soiled hotpads to remove pizza trays from the oven.</p> <p>-Using those same gloves touched multiple surfaces in the kitchen including oven doors.</p> <p>-Using those same gloves then touched personal size pizzas when putting them in the steam table.</p> <p>*Had a tray of personal size pizzas in the steam table layered with brown paper.</p> <p>*Inserted the thermometer through the pizza and paper layers to get the temperature of that pizza.</p> <p>*Inserted the thermometer through plastic wrap covering pureed bread to get the temperature of that bread.</p> <p>*During meal service she washed her hands, picked up plastic wrap from the floor, then did not wash her hands before putting gloves on.</p> <p>Observation of the 3/22/16 lunch meal revealed cook B:</p> <p>*Inserted the thermometer all the way to the bottom of food pans to obtain food temperatures.</p> <p>*Wiped the thermometer down with an alcohol wipe but did not allow the thermometer to air dry before taking other food temperatures.</p> <p>Interview on 3/23/16 at 1:15 p.m. with the dietary manager revealed:</p> <p>*He had not watched cook A take temperatures of food before.</p> <p>-She had been hired in the summer of 2015.</p> <p>*He had not noticed her glove use.</p>	F 371	<p>appropriate glove use to Cook A by May 12, 2016.</p> <p>The Dietary Services Manager will provide education regarding appropriate cleaning and use of the thermometer for food temperature monitoring and appropriate glove use to Cook B by May 12, 2016.</p> <p>The Dietary Services Manager and/or Director of Clinical Education provided in-service to the dietary staff on April 11, 2016 regarding appropriate method of taking food temperatures and appropriate hand hygiene and glove use for assigned tasks.</p> <p>A new hire orientation list and annual education schedule are developed/put back into use for the dietary department effective April 11, 2016.</p> <p>Dietary Services Manager will perform audits on hand hygiene, appropriate glove use and proper food temperature procedures 1x weekly for 3 months.</p> <p>Dietary Services Manager will report results of the audits to QAPI monthly for review of effectiveness, revisions, and recommendations.</p>	

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F 371	Continued From page 2 *He had not realized cook B had touched the bottom of the food pans with the thermometer. *He agreed staff should have taken food temperatures properly. *He would go over proper food temperature procedures with staff.  Review of the 3/3/16 Food Thermometer Guidelines policy revealed: *Thermometers should be washed, rinsed, and air-dried before each use. *Only clean air dried thermometers should have been put into a food item. *The thermometer should have been put into the thickest part of a food item. *The end (sensor) of the thermometer should not touch the bottom or sides of a pan.  Review of the 2/12/15 Infection Control-Hand Washing policy revealed hands should have been washed: *After handling "any soiled or contaminated equipment, cleaning cloths, utensils, dishes, trays...". *After picking up anything from the floor.	F 371	<b>F387</b> Residents 6, 11, and 13 have had their medical record reviewed for physician's visits. Physicians have been contacted regarding delinquency of mandatory visits.  All residents in the facility have the potential to be affected in a similar manner.  The Health Information Manager (HIM) reviewed all resident's medical records for the date of the last physician visit. Executive Director, Director of Nursing, and Health Information Manager have developed a system for Golden Living Center Bella Vista for Physician Visits, which the HIM will track, monitor and inform the physician when the next required visit is due. If the physician is noncompliant with visits, the HIM will notify the Director of Nursing and/or Executive Director for further follow-up with the primary care physician and the Medical Director.		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT  The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387	The HIM will audit/monitor the physician visits monthly and report the findings to QAPI monthly for 3 months for review of effectiveness, revisions, and recommendations.	*5/12/16 NS/SDD/HCL	

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F 387	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29162 Based on record review, interview, and policy review, the provider failed to ensure the required physicians' sixty day recertification visits were completed for three of seventeen sampled residents (6, 11, and 13). Findings include:</p> <p>1. Review of resident 6's medical record revealed he had been admitted on 10/8/98. He had been seen by his physician on 6/9/15 and 1/6/16. No record of a visit was found between 6/9/15 and 1/6/16.</p> <p>Interview on 3/23/16 at 2:00 p.m. with the director of nurses confirmed resident 6 had not been seen for a physician recertification visit for greater than thirty days. She stated she had reviewed the resident's complete medical record and contacted his physician's clinic health information staff. There had not been a record of physician's visits for the resident during the above time frame.</p> <p>Interview on 3/23/16 at 3:00 p.m. with the health information management person revealed she: *Kept a log for all residents to know when physicians' sixty day visits were due. *Would send a facsimile (FAX) to the physician's office approximately two weeks before the sixty day visits were due if the physician had not been there. *Would send another FAX to the physicians' office if the visit became delinquent (late). -Did not have a specific time frame in which she sent the above FAX. *Notified the director of nurses (DON) if the physician's visit remained delinquent. -Did not have a specific time frame in which she</p>	F 387		

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F 387	Continued From page 4 notified the DON. *Did not have any tracking in place to verify physician progress notes had been received. Surveyor: 26632 2. Review of resident 11's medical record revealed she had been seen by her physician on 5/25/15, 8/3/15, and 10/31/15. Physician's visits for December 2015 and February 2016 had been missed.  3. Review of resident 13's medical record revealed she had been seen by her physician on 5/21/15, 7/2/15, and 9/24/15. Physician's visits for October and December 2015, and February 2016 had been missed.  4. Review of the provider's last reviewed 10/15/15 Monitoring Physician Visits policy revealed: *Note the date of each visit by the attending physician on the physician visit control log. *If the physician did not visit by the due date, the health information management (HIM) coordinator would send a delinquent visit notification letter. *That letter informed the physician that an alternate physician or the medical director would visit the resident if the primary physician did not see the resident within the next ten days. *A copy of the letter would have been filed in the HIM office and the executive director (ED) would have been informed of that action. *The ED would request the alternate physician or medical director see the resident if the primary physician did not respond and the resident agreed.	F 387	<b>F441</b> CNA C will receive education on proper handwashing and a skills checklist will be completed by the DNS or designee. CNA C will receive education for proper glove use while providing resident care. CNA D will receive education on proper catheter care, maintain a clean area to provide the cares. LPN J will receive education on proper handling of the eye drop box. This education will be completed by May 12, 2016.  All residents in the facility have the potential to be affected in a similar manner.  The Director of Nursing will review policies and procedures about hand hygiene and glove use for assigned tasks.  The Director of Nursing and/or Director of Clinical Education will provide education for all staff of hand washing, glove use, creating and clean area during provision of resident care, management of resident eye drops and catheter care. The Director of Nursing or designee will audit handwashing, glove, catheter care and eye drop	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 5 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by:	F 441	administration 3 times per week for 4 weeks and monthly for 2 months. The Director of Nursing or designee will report the outcome of the audits to QAPI monthly x3 months for review of effectiveness, revisions, and recommendations.	*5/12/16 NS/SDDOH/EL

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F 441	<p>Continued From page 6 Surveyor: 29162 Based on observation, interview, and policy review, the provider failed to ensure:</p> <p>*Handwashing was completed in an effective manner by one of three certified nurse aides (CNA) (C). *Appropriate placement and handling of an eye drop box by licensed practical nurse (LPN) J during one of one eye drop administration for resident 15. *Disposal of soiled supplies had been completed in an appropriate manner by one of one CNA (D) observed during catheter care for resident 7. Findings include:</p> <p>1. Observation on 3/22/16 at 11:38 a.m. of CNA C while he washed his hands revealed he turned the water on at the sink. He washed and rinsed his hands with soap and water for eight seconds. He shut off the water faucets with his clean hands and then dried his hands with paper towels.</p> <p>2. Observation on 3/22/16 at 10:30 a.m. of CNA D while she completed supra-pubic catheter care (tube for urine drainage placed through the lower abdomen) for resident 7 revealed she: *Put the soiled dressing from the catheter tubing directly onto the resident's clean bedspread. *Used six alcohol pads to clean the resident's catheter. *Put the alcohol pads directly onto the resident's clean bedspread after she had used them. *Gathered all of the soiled supplies from the resident's bedspread and put them in the garbage when she was done.</p> <p>3. Observation on 3/22/16 at 9:30 a.m. of LPN J while she prepared and administered eye drops to resident 15 revealed she:</p>	F 441		

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F 441	<p>Continued From page 7</p> <p>*Put the eye drop box containing the resident's eye drops directly into her uniform pocket. *Removed the eye drop box from her uniform pocket and removed the eye drop bottle. *Put the box directly onto the resident's pillow case in the area above his head. *Administered the eye drops. *Picked up the eye drop box from the resident's pillow case and put the bottle of eye drops into it. *Placed that soiled eye drop box back into the clean medication cart.</p> <p>4. Interview on 3/23/16 at 2:00 p.m. with the director of nurses revealed she agreed: *Employee C had not washed his hands correctly. *The soiled dressing and used alcohol pads should not have been placed on resident 7's bedspread. *Resident 15's eye drop box should not have been put in LPN J's pocket or on resident 15's pillow. -She stated she would have expected LPN J to have left the eye drop box on the medication cart.</p> <p>Surveyor: 26632</p> <p>5. Observation on 3/22/16 at 8:00 of CNA C while he provided personal care for resident 14 revealed: *He washed his hands for approximately ten seconds, shut the faucets off with his wet hands, and then dried his hands. *He put on gloves. *CNA F came into the room to assist CNA C. She went to wash her hands and stated there was no soap in the soap dispenser. *CNA C then assisted resident 14 from her bed to the wheelchair. *He assisted her from the wheelchair to the toilet. *The seat of her wheelchair was wet when she</p>	F 441			

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F 441	<p>Continued From page 8</p> <p>was transferred.</p> <p>*He removed her soiled incontinence brief.</p> <p>*He removed his gloves and did not wash or sanitize his hands.</p> <p>*He retrieved clothes and a clean brief from her drawer.</p> <p>*He washed his hands for approximately five seconds, shut the faucets off with his wet hands, and then dried his hands.</p> <p>*He put on gloves and assisted her to put on her pants and top.</p> <p>*He provided perineal care (cleansing of private area), applied a cream to her perineal area, and then removed his gloves.</p> <p>*Without washing or sanitizing his hands and without gloves he then put a clean incontinence brief on her and assisted her back into the wheelchair.</p> <p>*He took a dry paper towel and briefly wiped the wheelchair seat.</p> <p>*He assisted her in the wheelchair to the hall.</p> <p>*He was not observed to have washed or sanitized his hands.</p> <p>Interview on 3/23/16 at 9:50 a.m. with CNA C revealed he provided the best care he could in the time he was allowed. He had not thought his handwashing or glove use was a problem.</p> <p>Interview on 3/23/16 at 11:00 a.m. with the director of nursing revealed she would have expected CNA C to have either washed his hands or used alcohol hand sanitizer between changing gloves.</p> <p>Review of the provider's revised August 2014 Handwashing/Hand Hygiene policy revealed: *All personnel should have followed the handwashing/hand hygiene procedures to help</p>	F 441			

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F 441	Continued From page 9 prevent the spread of infection to other personnel, residents, and visitors. *Hand hygiene products and supplies (sinks, soap, towels, and alcohol-based hand rub) should have been readily accessible and convenient for staff. *Use of an alcohol-based hand rub or soap and water should have been used for situations including: -Before and after direct contact with residents. -Before moving from a contaminated body site to a clean body site during resident care. -After contact with a resident's intact skin. -After contact with medical equipment in the immediate vicinity of the resident. -After removing gloves. *Hand hygiene was the final step after removing and disposing of personal protective equipment. *The use of gloves did not replace handwashing/hand hygiene. *Faucets should have been turned off with a clean, dry paper towel after handwashing.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435060</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/23/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</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 initial comments on asterisk per 4/18/16 per telephone with facility</i></p> <p>Surveyor: 32334 Administrator. LF/SDDOHJEL</p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 3/23/16. Golden LivingCenter - Bella Vista 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 deficiencies identified at K051 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p><b>STATEMENT OF COMPLIANCE:</b> 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.</p>	
K 051 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System</p>	K 051	<p><b>K051</b></p> <p>The alarm system malfunction was corrected March 28, 2016, invoiced on April 6, 2016. When in silent mode the system now functions properly, with doors remaining unlocked.</p> <p>All residents have the potential to be affected.</p> <p>The silent mode function of the facility fire alarm system will be monitored/audited for proper function monthly with the scheduled fire drills and documented with</p>	<i>*5/12/16 LF/SDDOHJEL</i>

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

TITLE

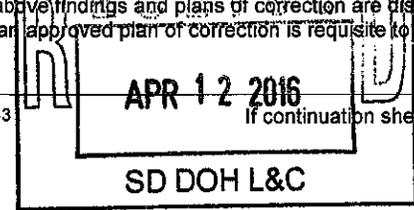
(X6) DATE

*Debra McLaugh*

*NHA*

*4/11/2016*

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



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

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NAME OF PROVIDER OR SUPPLIER  <b>GOLDEN LIVINGCENTER - BELLA VISTA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>302 ST CLOUD STREET RAPID CITY, SD 57701</b>		
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K 051	<p>Continued From page 1 records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the fire alarm system was installed and maintained in accordance with NFPA 72, National Fire Alarm Code (fire alarm system not functioning correctly). Findings include:</p> <p>1. Observation at 10:50 a.m. on 3/23/16 during a fire drill revealed the fire alarm system was not functioning correctly. Upon completion of the fire drill, the fire alarm system was put into silent operating mode. That mode should have kept the fire alarm system in alarm status and just muted the horns and strobes from operating. While in silent mode the magnetic door hold opens for smoke barrier doors and magnetic door locks for exit egress doors were able to be reset. Those magnetic devices shall remain inactive during silent operating mode.</p> <p>Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he was unaware of that condition. The indicated the fire alarm panel was new. He suggested the fire alarm system was probably not installed correctly with the new fire alarm panel.</p> <p>This deficiency has the potential to affect six of six smoke compartments and all seventy-three residents.</p>	K 051	<p>the monthly preventative maintenance plan.</p> <p>The Maintenance Supervisor will report the findings to QAPI monthly, for 3 months.</p> <p><b>K069</b> The makeup air system providing excessive air flow when the kitchen exhaust ventilation system is turned on will be corrected by May 12, 2016.</p> <p>All residents have the potential to be affected.</p> <p>The Dietary Manager, in conjunction with the Maintenance Supervisor will monitor the air flow of the exhaust ventilation system and makeup air weekly times 12 weeks and the Maintenance Supervisor will report the findings to QAPI for 3 months.</p>	
K 069 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance</p>	K 069		

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K 069	<p>Continued From page 2 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provided failed to ensure the commercial kitchen hood ventilation system was in compliance with applicable codes. The commercial kitchen hood system was not being used during cooking operations as required by NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Findings include:</p> <p>1. Observation at 11:15 a.m. on 3/23/16 in the kitchen revealed a commercial kitchen hood system over the cooking appliances. The stove was turned on at the time of observation however the commercial kitchen exhaust ventilation system was not turned on. The exhaust system was then tested by turning it on which also activated the makeup air (replacement air) system. The makeup air provided substantial air flow that blew cooking supplies around, was loud, and was cold untempered air. The make-up air did not provide a comfortable working environment. That appeared to be the reason the dietary staff did not wish to use the commercial ventilation system. The make-up air provided enough air flow to create a positive air pressure balance in the kitchen. That provided the potential to push cooking odors and smoke to adjoining use areas. The kitchen ventilation system shall be designed to create a slight negative air pressure in relation to adjoining areas.</p> <p>Interview with the dietary supervisor at the time of the above observation confirmed that condition. He did not indicate if that issue had been questioned prior to this survey.</p>	K 069		

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K 069	Continued From page 3  This deficiency has the potential to affect one of six smoke compartments.	K 069		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10667	(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 - BELLA VISTA**

STREET ADDRESS, CITY, STATE, ZIP CODE  
**302 ST CLOUD ST  
RAPID CITY, SD 57701**

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S 000	Compliance/Noncompliance Statement Surveyor: 23059 Surveyor: 32334 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 - Bella Vista was found not in compliance with the following requirements: S157 and S301.	S 000	<b>STATEMENT OF COMPLIANCE:</b> 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.	
S 157	44:73:02:13 Ventilation  Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system.  This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure exhaust ventilation was provided in the 300 wing janitor's closet. Findings include;  1. Observation at 1:45 p.m. on 3/23/16 revealed a janitor's closet in the 300 wing. The air in that room was musty with a strong chemical smell. Testing of the exhaust system with a tissue revealed the exhaust was not functioning properly. It was unable to pull the tissue onto the face of the exhaust grille.  Interview with the maintenance supervisor at the time of the above observation revealed he was unaware that exhaust in that room was not functioning. He did not indicate if checking of exhaust systems was provided on a regular	S 157	S157 The Maintenance Supervisor will repair the exhaust fan in the janitor closet on the 300 wing by May 12, 2016.  All residents have the potential to be affected.  The function of the exhaust fans will be monitored for proper function with the scheduled preventative maintenance program. The Maintenance Supervisor will	*5/12/16 NS/SDDOH/EL  *weekly NS/SDDOH/EL

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

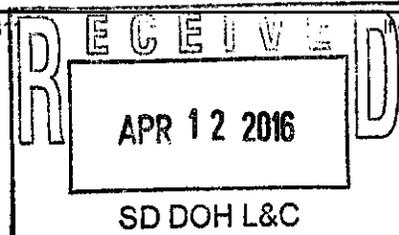
*Debra McHugh*

TITLE

N/A

(X6) DATE

4/11/2016



South Dakota Department of Health

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S 157	Continued From page 1 preventative maintenance schedule.	S 157	report the findings to QAPI monthly for 3 months. *The QAPI committee will determine further actions for S301 monitoring. NS/SDDOHH/EL	
S 301	<p>44:73:07:16 Required Dietary Inservice Training</p> <p>The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32573 Based on observation and interview, the dietary manager failed to ensure ongoing inservice training had been provided for all dietary employees for proper food handling, temperature control, and serving procedures. Findings include:</p> <p>1. Observation on 3/21/16 of the supper meal revealed cook A: *Had not properly taken temperatures of foods. *Stated "so I have to wait until it is that temperature?" when cold food had not been cool enough to serve. *Had not been aware of the proper holding temperatures for hot or cold food. *Had not used proper glove technique throughout the meal service. -Touched soiled hot pads and oven doors with gloves then touched food with the same gloves. -Picked something off the floor and put on gloves without washing hands.</p> <p>Interview on 3/23/16 at 1:15 p.m. with the dietary</p>	S 301	<p>The Dietary Services Manager will provide education for the dietary staff members on April 11, 2016 regarding food temperatures, proper glove use, maintaining proper food temperatures and hand washing.</p> <p>All residents have the potential to be affected.</p> <p>The Dietary Services Manager will audit food temperatures, proper glove use and handwashing 3 times per week for 3 months.</p> <p>The Dietary Services Manager will report the finds to QAPI monthly for 3 months.</p> <p>*The QAPI Committee will determine further actions for monitoring. NS/SDDOHH/EL</p>	*5/12/16 NS/SDDOHH/EL

\*FO include cook A.  
NS/SDDOHH/EL

South Dakota Department of Health

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S 301	Continued From page 2  manager revealed: *Cook A was "new." -Cook A had been hired in the summer of 2015. *He had never seen her take food temperatures. *He had not done any training with cook A since she had started because he was sending her to ServSafe training. -New employees were sent to ServSafe training as their orientation training. -He had not had any other training in place upon her being hired other than ServSafe. *Cook A had not gone to ServSafe training yet. *He agreed he should go over some training with her.	S 301		
S 000	Compliance/Noncompliance Statement  Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 3/21/16 through 3/23/16. Golden LivingCenter - Bella Vista was found in compliance.	S 000		