

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

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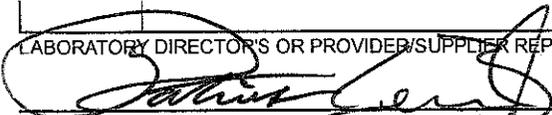
PRINTED: 10/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435080</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>10/09/2014</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHESDA OF BERESFORD</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>606 W CEDAR<br/>BERESFORD, SD 57004</b> |
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| F 000         | INITIAL COMMENTS<br><br>Surveyor: 33265<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/6/14 through 10/9/14. Bethesda of Beresford was found not in compliance with the following requirements: F176, F241, F248, F279, F314, F315, F323, and F441.  | F 000 | <p>Addendums noted with an asterisk per 11/7/14 telephone to facility administrator. SCSDDOH/IMF</p> <p><b>F176 - RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</b></p> <p>Resident #19's nebulizer treatments were discontinued by the primary care physician due to resident refusal. Resident #16 had a self-administration of medications assessment completed. As a result, the resident was found to be safe to administer their own nebulizer.</p> <p>The Policy and Procedure for Self Administration of Medications was reviewed and revised <del>by the staff</del> <i>development coordinator.</i> An in-service training will be provided to staff 11/07/2014 on the Self-Administration Policy and Procedure with regard to nebulizer treatments. All residents on nebulizer medications will have their physician assess to determine if they are capable of using the inhaler form of medication. If the inhaler is deemed not appropriate, and the route of administration for nebulizer treatment is necessary, the resident will have a self-administration of medications assessment performed.</p> |  |
| F 176<br>SS=D | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32355<br>Based on observation, record review, interview, and policy review, the provider failed to ensure one of one randomly observed resident (16) and one of one randomly interviewed resident (19) who self-administered a medication had been assessed for their capability to self-administer medications. Findings include:<br><br>1. Interview on 10/6/14 at 2:50 p.m. with resident 19 revealed:<br>*He had a nebulizer machine (delivers the nebulizer treatment medication), mask, and chamber sitting on his bedside table.<br>*He would have received a nebulizer treatment a couple times throughout the day.<br>*After the staff had placed the mask and chamber on his face for administration of the medication | F 176 |  |  |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>11/03/2014</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.

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If continuation sheet Page 1 of 43

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| F 176  | <p>Continued From page 2</p> <p>-Not monitored the resident to ensure the medication had been fully delivered and without difficulties.</p> <p>Interview on 10/8/14 at 10:10 a.m. with RN B revealed:<br/>*She was not aware resident 16 had completed the nebulizer treatment and left the room.<br/>*She had not been aware resident 16 had no physician's order or an assessment to support the ability to self-administer the nebulizer treatment.</p> <p>Review of resident 16's medical record revealed:<br/>*There was not a physician's order for her to self-administer the nebulizer treatment.<br/>*There was not a self-administration assessment completed by the licensed nurse.<br/>*The self-administration of the nebulizer treatment was not addressed on her current care plan.</p> <p>Interview on 10/8/14 at 3:30 p.m. with the staff development nurse regarding residents 16 and 19 revealed she:<br/>*Was not aware a self-medication assessment should have been completed on any resident left unattended during a nebulizer treatment.<br/>*Confirmed a self-administration assessment had not been completed for them regarding their capability to self-administer the nebulizer treatments.</p> <p>Review of the provider's 4/28/04 Self-Administration of Meds (medications) policy revealed:<br/>**"It is the policy of [provider name] to evaluate for safety and suitability any resident who desires to self-administer their medications."<br/>**"Initial screening tool for evaluating</p> | F 176   |   |                      |   |

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| F 176  | Continued From page 3<br>self-administration of medications will be performed by the nurse after resident expresses desire to self-medicate."<br>**Obtain MD (medical doctor) order for medication for resident to self-administer medication pending successful facility evaluation."<br>*The ability to self-administer medications should have been located on either the medication administration record or the treatment record.<br>**The resident's care plan should be updated to include the self-administration of medication per facility policy."   | F 176   |  |                      |   |
| F 241<br>SS=E  | <b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b><br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32335<br>Based on observation, interview, and policy review, the provider failed to maintain a homelike environment for five of five assisted feeding tables by not using tablecloths, cloth napkins, center pieces, and by not having easy access to assist one of one sampled resident (14) during two of two meal observations. Findings include:<br><br>1. Observations on 10/6/14 from 5:25 p.m. through 5:50 p.m. in the assisted feeding dining room revealed:<br>*It was located in the therapy room off the main dining room. | F 241   | <b>F 241 - DIGNITY AND RESPECT OF INDIVIDUALITY</b><br><br>The Bethesda interdisciplinary team will assess the current dining room and table set up to promote a homelike environment for all residents.<br>The following changes will occur:<br><ul style="list-style-type: none"> <li>• The Dietary Manager will order more tablecloths and cloth napkins to ensure that all residents and all tables have them. Centerpieces will also be placed on all resident dining tables.</li> <li>• The Dietary Manager will set up extended dining times to allow for all residents to dine in the main dining room.</li> <li>• The adjacent room will no longer be used for resident dining.</li> <li>• Dining room tables have been moved away from the walls for an enhanced dining experience.</li> </ul> An all staff in-service training will be held on 11/06/2014, addressing new dining room procedures. The Resident Criteria for Assisted Diners and Dining Room Arrangements Policies and |                      |   |

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| F 241  | <p>Continued From page 4</p> <ul style="list-style-type: none"> <li>-A Nu-step (exercise bike) was in the room.</li> <li>-Three pulleys were located on the one wall.</li> <li>-Exercise balls and other equipment were on a shelf in the corner of the room.</li> <li>-A desk was in the corner of the room.</li> <li>*There was one square table next to the Nu-step machine with one resident sitting at the table facing the wall.</li> <li>*There were two rectangular tables with one side of each table pushed up against the wall.</li> <li>*No tablecloths, cloth napkins, or centerpieces were on any of the tables.</li> <li>*Resident 14 had been placed next to the wall.</li> <li>*An unidentified staff member stood behind resident 14 and reached over the back of her wheelchair to assist her with her food.</li> </ul> <p>Observation on 10/7/14 at 11:25 a.m. in the assisted dining room and the main dining room revealed:</p> <ul style="list-style-type: none"> <li>*Closest to the assisted dining room were two rectangular assisted tables with one side of each table pushed up against the wall.</li> <li>*The non-assisted tables had tablecloths, cloth napkins, and centerpieces on them.</li> <li>*The five assisted tables had no tablecloths or centerpieces and had paper napkins instead of cloth napkins.</li> <li>*Resident 14 had been placed next to the wall.</li> <li>*Certified nursing assistant F stood behind resident 14 and reached over the back of her wheelchair to assist her with her food.</li> </ul> <p>Interview on 10/7/14 at 12:25 p.m. with the dietary manager regarding the assisted feeding tables revealed:</p> <ul style="list-style-type: none"> <li>*There were two residents who liked to pull at things while at the table which was why they did not have tablecloths.</li> </ul> | F 241   | <p>Procedures will be updated to reflect this change.</p> <p>The Dietary Manager or designee will audit the dining room during meals to assure table cloths, cloth napkins and center pieces are on all tables, no tables are pushed against the wall weekly for 4 weeks then monthly x 3 months.</p> <p>The Dietary Manager will monitor progress and report the results of the dining room changes to the QAPI Committee * [redacted] quarterly * w/afii<br/>scsddh/mf</p> <p>determined by the committee to be resolved. scsddh/mf</p> | <p>* 11/8/14<br/>[redacted]<br/>scsddh/mf</p> |   |

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| F 241  | Continued From page 5<br>*She could not explain why all five assisted tables had no tablecloths since there were only two residents with concerns.<br>*She was unable to explain why no assisted tables had centerpieces, and why they had been using paper napkins instead of cloth napkins.<br>*She was unable to explain why the assisted tables had been pushed up against the wall.<br>*They had never thought about rearranging the tables to integrate the assisted and non-assisted tables.<br><br>Interview on 10/7/14 at 6:00 p.m. with the registered dietician revealed she was not aware of why the tables had been pushed up against the wall or why they had no tablecloths on the tables.<br><br>Review of the provider's 8/23/12 Dining Room Arrangements policy revealed:<br>**Seating arrangements are made on the basis of [of] service, compatibility, and resident needs, not on the basis of race, color, creed, national origin, age, sex religion, diet, or handicap."<br>**Seating arrangements are developed and revised as necessary to accommodate the needs of each resident and to take into account any discharges or new admission."<br><br>Review of the provider's admission packet information revealed "The resident has the right to be cared for in a manner and environment that will maintain or enhance their quality of life; their dignity and respect in full recognition of their individuality." | F 241   |   |                      |   |
| F 248<br>SS=E  | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br><br>The facility must provide for an ongoing program  | F 248   |   |                      |   |

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| F 248  | <p>Continued From page 6</p> <p>of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355<br/>Based on observation, interview, record review, and policy review, the provider failed to ensure activities were developed based on residents' individual needs for 4 of 13 sampled residents (2, 3, 4, and 14). Findings include:</p> <p>1. Random observations from 10/6/14 through 10/8/14 of resident 2 revealed:<br/>*When he had not been in the dining room for meals he was resting in his bed.<br/>*He had been observed sitting in the common area twice and appeared to be sleeping both times.<br/>*No TV or radio had been provided for auditory (hearing) and mental stimulation in his room.<br/>*His room had always been dark, and the window curtains were pulled shut.<br/>*No one-on-one activity or visits had been observed from activities, nursing staff, or social services (SS).<br/>*Staff had only been observed in his room during assistance with activities of daily living (ADL).</p> <p>Review of resident 2's current care plan revealed:<br/>*No focus area addressing his needs and preferences for activities.<br/>*A problem area stating:<br/>-"Need for nursing home placement with an approach to provide clock and activity calendar in room."</p> | F 248   | <p><b>F 248 - ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT</b></p> <p>Residents #2, 3, 4 and 14 will receive the following corrective action:</p> <ul style="list-style-type: none"> <li>• A letter will be sent to each family and/or legal representative asking for input regarding the resident's personal interests and/or activities that they may enjoy.</li> <li>• The Activity Manager will attempt to reach families that do not respond to the aforementioned letter by phone after 1-week.</li> <li>• If unsuccessful with family or legal representative contact, Bethesda will follow the Individual Activities Policy and Procedure on obtaining potential resident individualized activities and interests.</li> <li>• Information gathered from following the Individual Activities Policy and Procedure will be incorporated into an individualized form for each resident and maintained in the Activities Department records.</li> </ul> <p>This same procedure will be performed for all current residents at the time of their next MDS assessment. It will also be performed on all new admissions and reviewed at each subsequent MDS assessment</p> |                      |   |

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| F 248  | <p>Continued From page 7</p> <p>-"Risk for miscommunication and social isolation d/t [due to] hearing impairment." Social services and activities were to have provided one-on-one visits to allow him to voice his concerns. The staff were to have offered alternative activities as needed (prn).</p> <p>*No goals were documented for any of the problem areas listed or for him to meet for activities.</p> <p>Review of resident 2's 5/19/14 Care Area Assessment summary revealed:<br/>*Activities had been marked as a problem area.<br/>*The current care plan should have been updated, continued, or a new one initiated that addressed activities for the resident.</p> <p>Review of resident 2's 8/8/14 activities quarterly assessment note revealed:<br/>*He was a quiet man, hard of hearing, and would not have engaged in conversation with others.<br/>*He would have occasionally sat in the commons area and watched people.<br/>*No documentation to support any one-on-one visits had occurred.<br/>*No documentation to support he had goals for activities and if he was able to meet them.</p> <p>Review of resident 2's September 2014 one-on-one visits weekly record revealed the activities staff had visited with him once a week.</p> <p>Review of resident 2's August 2014 one-on-one programming activity log revealed:<br/>*The activity staff had attempted to visit with him three days out of a total of thirty-one days.<br/>*Those one-on-one visits had been attempted in the hallway.<br/>*No documentation to support any other type of</p> | F 248   | <p>An in-service training by the Activities Manager will occur on 11/06/2014, reviewing the Individual Activities Policy and Procedure for the Activities Assistants.</p> <p>The Activities Manager or designee will audit the use of the resident *individualized form</p> <p> <i>SCSDDDHMF</i></p> <p><i>* weekly on all residents scheduled for mds assessments each week and audit 3 individual activities weekly for 4 weeks, then monthly for 3 months and report the results to the QAPI committee quarterly until determined by the committee to be resolved. SCSDDDHMF</i></p> | <p><i>11/8/14</i></p> <p><i>SCSDDDHMF</i></p>       |

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| F 248  | <p>Continued From page 8</p> <p>one-on-one activity had been attempted during August.</p> <p>Review of resident 2's September 2014 one-on-one programming activity log revealed:<br/>*The activity staff had attempted to visit with him five days out of a total of thirty days.<br/>*Those one-on-one visits had only been conversational.<br/>*No documentation to support any other type of one-on-one activity had been attempted during September.</p> <p>Interview on 10/9/14 at 9:00 a.m. with the activity director regarding resident 2 revealed:<br/>*All of her one-on-one visits had been conversations.<br/>*No other special stimulation techniques had been attempted.<br/>*She stated "We have fallen behind with him and he needs more one-on-one activity for stimulation."<br/>*He had been hard to do one-on-one activities d/t his hearing problems and fluctuation in behaviors.<br/>*She had not recognized a problem with the care plan.</p> <p>Surveyor: 32335<br/>2. Random observations from 10/6/14 through 10/9/14 of resident 3 revealed:<br/>*She had watched a movie with a group of residents.<br/>*Half-way through the movie she had appeared to be sleeping.<br/>*She had been observed sitting in the common area on two occasions.</p> <p>Review of resident 3's 6/24/14 significant change</p> | F 248   |   |   |

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| F 248  | <p>Continued From page 9</p> <p>Minimum Data Set (MDS) assessment revealed:<br/>*Her thinking ability was severely impaired.<br/>*The activity preferences that were very important to her included:<br/>-Doing things with groups of people.<br/>-Doing her favorite activities.<br/>-Going outside.<br/>-Participating in religious activities.<br/>*The activity preferences that were somewhat important to her included:<br/>-Having books, magazines, and newspapers available to read.<br/>-Listening to music she liked.<br/>-Keeping up with the news.</p> <p>Review of resident 3's current care plan revealed:<br/>*No focus area addressing her needs and preferences for activities.<br/>*A problem area stated:<br/>-Need for nursing home placement with an approach to "provide clock and activity calendar in room."<br/>*A problem area stated:<br/>-Diagnosis of depression with an approach to provide one-to-one visits regarding "areas of concern."<br/>*A problem area stated:<br/>-She was at risk for social decline as she was new to the facility with an approach to "invite _____ [resident's name] to social activities."<br/>*No other activity goals or approaches had been care planned or implemented.</p> <p>Review of the activity program's one-to-one list revealed she had not been listed as receiving one-to-one activities.</p> <p>3. Random observations from 10/6/14 through 10/9/14 of resident 4 revealed:</p> | F 248   |   |                      |   |

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| F 248  | <p>Continued From page 10</p> <p>*When he had not been in the dining room for meals he was in his room.</p> <p>*When he was in his room it had been dark, and the door was closed.</p> <p>Review of resident 4's 8/23/14 annual MDS assessment revealed:</p> <p>*His thinking abilities were severely impaired.</p> <p>*He had no activity preferences listed that were very important to him.</p> <p>*The activity preferences that were somewhat important to him included doing his favorite activities but none were listed.</p> <p>Review of resident 4's current care plan revealed:</p> <p>*No focus area addressing his needs and preferences for activities.</p> <p>*A problem area stated:</p> <p>-Need for nursing home placement with an approach to "provide clock and activity calendar in room."</p> <p>*A problem area stated:</p> <p>-Diagnosis of depression with an approach to "encourage social activities as appropriate."</p> <p>*No other activity goals or approaches had been care planned or implemented.</p> <p>4. Random observations from 10/6/14 through 10/9/14 of resident 14 revealed she spent most of the time in her room in bed when she was not at meals.</p> <p>Review of resident 14's 2/19/14 and 8/9/14 MDS assessments revealed her:</p> <p>*Thinking abilities had gone from severely impaired and were currently moderately impaired.</p> <p>*Activity preferences that were very important to her included doing her favorite activities but none were listed.</p> | F 248   |   |   |

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| F 248  | <p>Continued From page 11</p> <p>Review of resident 14's current care plan revealed:<br/>*No focus area addressing her needs and preferences for activities.<br/>*A problem area stated:<br/>-Need for nursing home placement with an approach to "provide clock and activity calendar in room."<br/>*A problem area stated:<br/>-Risk for miscommunication due to hearing and vision impairment with an approach to provide one-to-one visits.<br/>*No other activity goals or approaches had been care planned or implemented.</p> <p>5. Review of the activity documentation revealed:<br/>*There were three different places staff had been documenting. Those places included:<br/>-The one-to-one activity log.<br/>-The monthly activities chart.<br/>-The activities progress notes.<br/>*One-to-one visits only included visiting as the activity.<br/>*Most of the visits occurred "in the common area" or in the "hallway."<br/>*The activity documentation completed by the activities staff had not been consistent.</p> <p>Interview on 10/9/14 at 9:00 a.m. with the activity director regarding residents 3, 4, and 14 revealed:<br/>*She had not identified individual activity likes on their care plans.<br/>*She had not used the MDS assessments to determine the residents' preferences.<br/>*She was not sure why resident 3 had one-to-one activity on her care plan as she was not on the list to receive one-to-one activities.</p> | F 248   |   |   |

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| F 248  | <p>Continued From page 12</p> <ul style="list-style-type: none"> <li>*She stated resident 4 liked to be in his room.</li> <li>*He also had behaviors that prevented him from participating in activities, but that had not been on the care plan.</li> <li>*She stated resident 14 was on hospice and liked to be in her room.</li> <li>*They had been doing one-to-ones with resident 14 which included visiting in the common areas and hallway.</li> <li>*She felt visiting in the common areas and hallways was not a problem.</li> <li>*She stated there were no activities policies.</li> <li>*She agreed the activities documentation had not been consistent and had not been done in a timely manner.</li> </ul> <p>Interview on 10/9/14 at 10:00 a.m. with the staff development coordinator revealed she had gone back and asked the activities director for the policies and procedures for the activity program. The activity director was unaware of where the policies were but handed her a binder to provide to the survey team. Review of the binder revealed the policies and procedures that had been requested.</p> <p>Review of the provider's 4/2/09 Activity Program policy revealed:</p> <ul style="list-style-type: none"> <li>*The objective of the activity program was "to provide a comprehensive plan which will be multi-faceted and reflect each individual resident's needs."</li> <li>**Therefore, the activities program will provide but not be limited to:             <ul style="list-style-type: none"> <li>-Promote physical, cognitive and/or emotional health.</li> <li>-Enhance to the extent practicable each resident's physical and mental status.</li> <li>-Promote each resident's self-respect by</li> </ul> </li> </ul> | F 248   |   |   |

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| F 248         | <p>Continued From page 13</p> <p>providing activities that allow for self-expression, personal responsibilities and choice."<br/>**"An ongoing program of activities be designed to meet the needs of each resident."</p> <p>Review of the provider's 4/2/09 Individual Activities policy revealed:<br/>**"As part of their total resident care, an activity program will be planned for them on an individual basis by the activity director in cooperation with the nursing staff."<br/>**"Individual activities are provided because residents have a need for personal identity."</p> <p>Review of the provider's 4/2/09 Activity Care Plan policy revealed "an individualized activity care plan is maintained for each resident."</p> <p>Review of the provider's 4/2/09 Activity Assessments policy revealed:<br/>**"The activity director will be responsible for developing an activity assessment."<br/>**"The purpose of the assessment is to describe the resident's capability to take part in and perform daily activity events."</p> | F 248 |  |  |
| F 279<br>SS=D | <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</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>   | F 279 | <p><b>F 279 - DEVELOP COMPREHENSIVE CARE PLANS</b></p> <p>Resident #3's chart and care plan was reviewed and compared to most recent CAAs on 10/30/2014. The following areas were addressed on the care plan at the time of surveyors' assessment:</p> <ul style="list-style-type: none"> <li>• Communication</li> <li>• Incontinence</li> <li>• Pain</li> </ul> |  |

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| F 279 | <p>Continued From page 14</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:<br/>Surveyor: 32335<br/>Based on observation, record review, interview, and policy review, the provider failed to have individualized and comprehensive care plans for 3 of 13 sampled residents (2, 3, and 4). Findings include:</p> <p>1. Review of resident 3's medical record revealed she had five urinary tract infections from 6/2/14 through 10/9/14.</p> <p>Review of resident 3's 6/24/14 Minimum Data Set (MDS) assessment revealed:<br/>*The following areas had been identified as concerns that needed to be care planned:<br/>-Cognitive (thinking) loss.<br/>-Communication.<br/>-Urinary incontinence.<br/>-Behavioral symptoms.<br/>-Falls.<br/>-Nutritional status.<br/>-Dehydration.<br/>-Pressure ulcers (a sore caused by unrelieved pressure that resulted in damage to tissue).<br/>-Psychotropic drug use (any medication capable</p> | F 279 | <p>Documentation exists on the care plan, MDS-CAA and CNA side sheets.<br/>The Bethesda interdisciplinary team reviewed risks for dehydration and the care plan was updated to reflect CAA trigger.<br/>Resident #4's chart and care plan was reviewed and the documentation that was present at the time of the surveyors audit was re-addressed by the Bethesda interdisciplinary team and they focused on TBI concerns with socially unacceptable behavior.<br/>Documentation exists in Social Service's notes and care plan.<br/>Resident #2's chart and care plan was reviewed. Education will be provided on 11/07/2014 to all direct care staff on comprehensive care plans and repositioning and prevention of pressure ulcers. Audits will be conducted by the Resident Care Coordinator or designee on three residents per week for four weeks then monthly for 3 months and the results will be reported at monthly QAPI meetings.<br/>Resident care plans will be assessed and updated with each resident MDS assessment and as needed due to a change in resident condition/status.</p> | <p>*by the staff development coordinator<br/>8/10/2014<br/>ME</p> <p>*and review of the policy and procedure changes<br/>8/10/2014<br/>ME</p> <p>*see page 16<br/>8/10/2014<br/>ME</p> |
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| F 279  | <p>Continued From page 15 of affecting the mind, emotions, and behavior).<br/>-Pain.</p> <p>Review of resident 3's current care plan revealed:<br/>*The following areas of concern identified in the MDS had not been care planned:<br/>-Communication.<br/>-Incontinence.<br/>-Dehydration.<br/>-Pain.</p> <p>2. Observations on 10/6/14 at 5:25 p.m. and on 10/7/14 at 11:25 a.m. of resident 4 revealed he had been sitting at a table in the assisted dining room by himself facing the wall. He was observed spitting at the wall and floors.</p> <p>Review of resident 4's medical record revealed he had suffered from a traumatic brain injury (TBI).</p> <p>Review of resident 4's current care plan revealed the TBI and sitting at the table alone due to his behaviors had not been addressed.</p> <p>Review of resident 4's 8/23/14 annual MDS assessment revealed:<br/>*His thinking abilities were severely impaired.<br/>*He had no activity preferences listed that were very important to him.<br/>*The activity preferences that were somewhat important to him included doing his favorite activities.</p> <p>Review of resident 4's current care plan revealed:<br/>*No focus area addressing his needs and preferences for activities.<br/>*A problem area stated:<br/>-Need for nursing home placement with an</p> | F 279   | <p>* [REDACTED] SC/SDDH/MF</p> <p>* Pressure Ulcer Prevention policy and procedure was developed and the direct care staff will be educated on the new policy on 11/7/14. SC/SDDH/MF</p> | <p>* 11/8/14<br/>SC/SDDH/MF</p>                     |

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| F 279  | <p>Continued From page 16</p> <p>approach to "provide clock and activity calendar in room."</p> <p>*A problem area stated:<br/>-Diagnosis of depression with an approach to "encourage social activities as appropriate."<br/>*No other activity goals or approaches had been care planned or implemented.</p> <p>Surveyor: 32355</p> <p>3. Review of resident 2's complete medical record revealed:<br/>*A re-admission date of 4/23/14.<br/>*Diagnoses of dementia (forgetfulness), depression (sadness), anxiety, and peripheral vascular disease (decrease blood supply to the legs), and a history of pressure ulcers (injury to the skin and underlying tissue) to his left foot.<br/>*He currently had an unstageable pressure ulcer to the outside of his left foot.<br/>*He recently had a facility acquired stage III pressure ulcer (shallow opening of the skin) to his left heel. That pressure ulcer had healed on 3/28/14.</p> <p>Observation on 10/7/14 from 1:20 p.m. through 4:00 p.m. of resident 2 revealed:<br/>*He had been resting in bed and lying on his back.<br/>*His heels had not been floated and were lying directly on the mattress.<br/>*He had no special devices in his bed to assist with pressure relieving measures for floating his heels and for repositioning such as pillows.<br/>*No heel protectors on his feet/heels.<br/>*No pressure relieving air mattress had been observed on his bed.<br/>*No observations of staff attempting to reposition him.</p> | F 279   |   |   |

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| F 279  | <p>Continued From page 17</p> <p>Observation on 10/8/14 from 8:50 a.m. through 11:00 a.m. of resident 2 revealed the same as the above.</p> <p>Observation on 10/8/14 at 11:20 a.m. of resident 2 revealed:<br/>*He had been positioned on his left side with a pillow behind his back.<br/>*The left side of his foot had been lying directly on the mattress. That had been the same location of his current pressure ulcer.</p> <p>Review of resident 2's 8/2/14 quarterly Minimum Data Set (MDS) assessment revealed he had been at risk for pressure ulcers. He had required extensive assistance with bed mobility, but there was no turning/repositioning program in place.</p> <p>Review of resident 2's current care plan revealed:<br/>*On 7/13/14 he had been moved to a different room.<br/>*He was to have worn heel protectors while in bed.<br/>*An approach to refer to the certified nursing assistants (CNA) side sheets.</p> <p>Review of resident 2's October 2014 CNA side sheets revealed:<br/>*On 5/16/14 he was to have had an air mattress on his bed at all times.<br/>*On 7/1/14 the CNAs were to have floated or off loaded (relieved pressure) both of his heels with pillows.</p> <p>Interview on 10/8/14 at 3:45 p.m. with the director of nurses regarding resident 2 revealed:<br/>*She had confirmed the CNA side sheets had been a part of the current care plan.</p> | F 279   |   |                      |   |

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| F 279  | Continued From page 18<br>*She would have expected a repositioning program to be in place.<br>*She would have expected the staff to follow both the current care plan and CNA side sheets.<br>*She had not been aware the staff had not been following the current care plan and CNA side sheets.<br>*Prior to 7/13/14 his bed had been equipped with an air mattress.<br><br>4. Review of the provider's undated Positioning the Body policy revealed:<br>*The purpose: "Maintain skin integrity and prevent injury of the musculoskeletal system [muscles of the body]."<br>*Staff were to "Avoid putting excess pressure on any body area."<br>*While laying on the back there should have been two pillows under each arm and a pillow underneath the feet/legs to decrease any excess pressure.<br><br>Review of the provider's 5/23/06 Resident Assessment and Care Planning policy revealed: "This is an interdisciplinary process which evolves to meet the individualized needs of the resident for necessary care and services to help each resident attain or maintain their highest level of practicable well being." | F 279   |  |                      |   |
| F 314<br>SS=G  | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having   | F 314   | <b>F 314- TREATMENT TO PREVENT/HEAL PRESSURE SORES</b><br><br>An overlay alternating air mattress was put on resident #2's bed and three pillows were placed in his room for use as positioning devices. Direct care staff |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435080</b>   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                |   | (X3) DATE SURVEY COMPLETED<br><br><b>10/09/2014</b> |
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| F 314  | <p>Continued From page 19</p> <p>pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32355</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (2) remained free from two provider-acquired pressure ulcers (injury to the skin and underlying tissue). Findings include:</p> <p>1. Review of resident 2's complete medical record revealed:<br/>*A re-admission date of 4/23/14.<br/>*Diagnoses of dementia (forgetfulness), depression (sadness), anxiety, and peripheral vascular disease (decrease blood supply to the legs), and a history of pressure ulcers to his left foot.<br/>*He currently had an unstageable pressure ulcer to the outside of his left foot.<br/>*He recently had a facility acquired stage III pressure ulcer to his left heel. That pressure ulcer had healed on 3/28/14.<br/>*No documentation to support when either of the pressure ulcers had originated.</p> <p>Observation on 10/7/14 from 1:20 p.m. through 4:00 p.m. of resident 2 revealed:<br/>*He had been resting in bed and lying on his back.<br/>*His heels were not floated and had been lying directly on the mattress.<br/>*He had no special devices on his bed to assist with pressure relieving measures for floating his</p> | F 314   |   |   |

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| F 314  | <p>Continued From page 20</p> <p>heels and for repositioning such as pillows.<br/>*No heel protectors on his feet/heels.<br/>*No pressure relieving air mattress was observed on his bed.<br/>*No observations of staff attempting to reposition him.</p> <p>Observation on 10/8/14 from 8:50 a.m. through 11:00 a.m. of resident 2 revealed the same as the above 10/7/14 observation.</p> <p>Observation on 10/8/14 at 11:20 a.m. of resident 2 revealed:<br/>*He had been positioned on his left side with a pillow behind his back.<br/>*The left side of his foot had been lying directly on the mattress. That was the same location of his current pressure ulcer.</p> <p>Observation on 10/9/14 at 8:30 a.m. of resident 2's bed revealed an air mattress overlay had been placed on top of the mattress.</p> <p>Review of resident 2's 8/2/14 quarterly Minimum Data Set (MDS) assessment revealed he had been at risk for pressure ulcers. He had required extensive assistance with bed mobility, but there was no turning/repositioning program in place.</p> <p>Review of resident 2's current care plan revealed:<br/>*On 7/13/14 he had been moved to a different room.<br/>*He was to have worn heel protectors while in bed.<br/>*An approach to refer to the certified nursing assistants (CNA) side sheets.</p> <p>Review of resident 2's October 2014 CNA side sheets revealed:</p> | F 314   | <p>will be educated at a mandatory nurse/CNA in-service training 11/07/2014. The current positioning policy was omitted and a new Pressure Ulcer Prevention and Treatment will be developed. This new policy will be presented at the direct care in-service training on 11/07/2014.</p> <p>See F 279 for positioning audits to be performed and reported by the Resident Care Coordinator or designee to the QAPI Committee.</p> <p>In-service training is to be completed upon hire with all new direct care staff and annually with all other direct care staff.</p> | <p>* 11/9/14<br/>[Redacted]<br/>S/S/2014/ME</p>     |

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| F 314  | <p>Continued From page 21</p> <p>*On 5/16/14 he was to have had an air mattress on his bed at all times.</p> <p>*On 7/1/14 the CNAs were to have floated or off loaded (relieve pressure) both of his heels with pillows.</p> <p>Review of resident 2's pressure ulcer/wound intervention flowsheet from 5/10/14 through 10/4/14 revealed he should have had:</p> <p>*Repositioning pillows.</p> <p>*A repositioning program in place.</p> <p>*Heel protectors.</p> <p>*A special mattress or pad.</p> <p>Review of resident 2's from 8/4/14 through 9/27/14 nurse's progress notes revealed:</p> <p>*No documentation to support:</p> <p>-The staff monitoring for the use of the heel protectors, and the use of any repositioning devices while he had been resting in bed.</p> <p>-His heels had been floated while in bed.</p> <p>-The air mattress overlay had been in place.</p> <p>Interview on 10/8/14 at 3:45 p.m. with the director of nurses revealed:</p> <p>*She had confirmed the CNA side sheets had been a part of the current care plan.</p> <p>*She would have expected a repositioning program to be in place.</p> <p>*The provider protocol was to have repositioned requiring assistance with mobility every two hours.</p> <p>*She would have expected the staff to follow both the current care plan and CNA side sheets.</p> <p>*She had not been aware the staff had not been following the current care plan and CNA side sheets.</p> <p>*Prior to 7/13/14 his bed had been equipped with an air mattress.</p> | F 314   |   |   |

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| F 314  | Continued From page 22<br>*She had not been aware the air mattress was not on his bed.<br>*She stated the air mattress overlay should have been moved with him to his new room.<br>*She confirmed he had acquired both of the pressure ulcers while under their care.<br>*She could not locate the original documentation on either of the pressure ulcers.<br>*The current left foot pressure ulcer on the outside of the foot had originated prior to her employment at the facility. She had been hired May 2013.<br><br>Review of the provider's undated Positioning the Body policy revealed:<br>*The purpose: "Maintain skin integrity and prevent injury of the musculoskeletal system."<br>*Staff were to "Avoid putting excess pressure on any body area."<br>*While laying on his back there should have been 2 pillows under each arm and a pillow underneath his feet/legs to decrease any excess pressure.<br><br>Review of the provider's 6/18/14 Skin Problem and Wound Documentation Procedures policy revealed:<br>*Purpose: "To monitor wound healing and determine effectiveness of current treatment orders."<br>*Policy: "All residents with skin breakdown will be monitored at least daily until healed. The monitoring process and effectiveness of current treatment orders and nursing interventions." | F 314   |   |                      |   |
| F 315<br>SS=E  | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a   | F 315   |   |                      |   |

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| F 315  | <p>Continued From page 23</p> <p>resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:<br/>Surveyor: 32335<br/>Based on record review and interview, the provider failed to assess and provide interventions for two of two sampled residents (3 and 4) with incontinence concerns who developed recurrent urinary tract infections (UTI). Findings include:</p> <p>1. Review of resident 3's 6/24/14 Minimum Data Set (MDS) assessment revealed urinary incontinence and dehydration had been identified as concerns.</p> <p>Review of resident 3's 3/24/14 and 9/20/14 MDS assessments revealed she had gone from frequently incontinent to always incontinent.</p> <p>Review of resident 3's current care plan revealed there were no goals or interventions for incontinence or dehydration. There had been one intervention added on 9/22/14 under the area of falls that stated "follow toilet schedule."</p> <p>Review of resident 3's medical record revealed she had five UTIs from 6/2/14 through 10/9/14. Those UTIs had not been addressed on the care plan.</p> | F 315   | <p><b>F 315 - NO CATHETER, PREVENT UTI, RESTORE BLADDER</b></p> <p>Residents #3 &amp; #4 have not had further UTIs since completion of the survey. Potential causes for the increased # of UTIs and recurrent UTIs have been considered.</p> <p>The policy for rinsing of urinary bags was revised to include rinsing bags with water prior to the bleach solution. The whirlpool disinfection process was reviewed and revised to meet the manufacturer's recommendations. Peri-care, catheter care and foreskin care was also reviewed for appropriate procedure in order to help prevent/decrease the incidence of resident UTIs.</p> <p>A policy and procedure will be developed regarding assessment and investigation of recurrent UTIs and incontinence assessment.</p> <p>Individual resident infection will be tracked to determine a trend in infections.</p> <p>Education will be provided to all direct care staff regarding UTI prevention, investigation of chronic infection, and incontinence assessment and management.</p> <p>Audits will be performed on the whirlpool disinfection, peri-cares, foreskin cares and foley catheter cares</p> | <p><i>*by the staff development coordinator SJSDDH/ME</i></p> <p><i>*by the staff development coordinator SJSDDH/ME</i></p> |

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| F 315 | <p>Continued From page 24</p> <p>2. Review of resident 4's 8/23/14 MDS assessment revealed urinary incontinence and dehydration had been identified as concerns. He had been frequently incontinent.</p> <p>Review of resident 4's current care plan revealed:<br/>*Incontinence had not been identified as a problem area.<br/>*Under the area of falls they had the following interventions:<br/>-"Uses urinal at night, assist every shift."<br/>-"4/17/14 commode at bedside for toileting schedule."<br/>-"Offer toilet between 8:00 p.m. and 8:30 p.m."</p> <p>Review of resident 4's medical record revealed he had a UTI on 6/16/14 and 7/29/14. Those UTIs had not been addressed on the care plan.</p> <p>3. Interview on 10/8/14 at 10:15 a.m. with the staff development coordinator revealed the toileting schedule was upon rising, mid-morning, before and after meals, mid-afternoon, and at bed time. There were no individualized toileting schedules for residents.</p> <p>Interview and record review on 10/8/14 at 2:20 p.m. with the assistant director of nursing revealed:<br/>*Incontinence had not been identified on either care plan for residents 3 or 4.<br/>*They had not utilized bladder assessments on any of the residents.<br/>*There were no individualized toileting programs for residents; they only had the toileting schedule.<br/>*The UTIs had been treated for each resident, but no additional interventions had been attempted.<br/>*They had discussed taking resident 4 to the</p> | F 315 | <p>3 times weekly for 4 weeks then monthly for 3 months by the Staff Development Coordinator or designee and results will be reported [REDACTED] quarterly to QAPI committee. SCSDDO/HMF</p> | <p>11/8/14<br/>SCSDDO/HMF</p> |
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| F 315  | Continued From page 25<br>bathroom at 3:00 p.m. each day. However that had not been added to the care plan or certified nursing assistant assignment sheets.<br>*They had no policy on urinary incontinence or regarding the toileting schedule.   | F 315   |  |   |
| F 323<br>SS=E  | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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 prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 16385<br>Based on observation, interview, and review of the manufacturer's operating instructions, the provider failed to ensure three of three observed EZ Way Stands (mechanical lifts used for transferring residents) had safety tabs per manufacturer's instructions. Findings include:<br><br>1. Random observations from 10/6/14 through 10/9/14 revealed:<br>*Two EZ Stand mechanical lifts had no safety tabs attached to the harness attachment area (Photos 1 and 2).<br>*One EZ Way Smart Stand mechanical lift was missing one of two metal safety tabs (Photos 3 and 4).<br>*Those safety tabs were to ensure the sling loops were secured within the harness hookup, so residents would not have fallen from the | F 323   | <b>F 323 – FREE OF ACCIDENT HAZARDS / SUPERVISION / DEVICES</b><br><br>The three EZ Way Stands safety tabs were re-attached to the harness to ensure Bethesda is meeting the manufacture's suggestions. The Resident Safety/Accidents Policy and Procedure will be updated to reflect the necessity of the safety tabs. Laminated "Safety Alerts" were placed on all the mechanical lifts. An in-service training will be provided to staff 11/07/2014 on the updated Resident Safety/Accidents Policy and Procedure.<br>The Environmental Services Manager or designee will conduct weekly audits to ensure compliance and report the results of the audit to the QAPI Committee <del>quarterly</del> quarterly.<br><i>* and will report any concerns to the administrator. scsdbchmf</i> | <i>* 11/13/14</i>                                   |

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| F 323  | Continued From page 26<br>mechanical lift.<br><br>Interview on 10/9/14 at 8:15 a.m. with the environmental services manager confirmed the safety tabs had been removed. He stated maintenance staff had replaced the safety tabs on all stand lifts multiple times.<br><br>Review of the provider's EZ Stand Operating Instructions maintenance checklist revealed:<br>**"The manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the device is put back into service."<br>**"4. Check to make sure the safety tabs for the harness hookup are not torn or broken." | F 323   |  |  |
| F 441<br>SS=E  | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program   | F 441   | <b>F 441 - INFECTION CONTROL, PREVENT SPREAD, LINENS</b><br><br>Hand Hygiene and Glove use policy and procedures were reviewed and revised. The whirlpool disinfection process was altered to meet manufacturer's recommendations. Laminated step-by-step instructions were posted on both whirlpool tubs. | <i>*by the staff development coordinator 10/09/14 MF</i> |

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Continued From page 27  
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:  
Surveyor: 33265  
Based on observation, interview, record review, and policy review, the provider failed to:  
\*Ensure policies and monitoring were in place for an infection control program.  
\*Complete blood sugar testing by one of one licensed practical nurse (LPN) (A) according to

F 441

*\* by the staff development coordinator.*  
An in-service training will be provided to all staff 11/06/2014 on hand hygiene and glove use. Additional education will be provided to all nursing staff on 11/07/2014 regarding hand hygiene during dressing changes and resident cares and on whirlpool disinfection.\*  
The Staff Development Coordinator or designee will perform audits on hand hygiene, glove use during cares and/or dressing changes, and whirlpool disinfection 3 times weekly for 4 weeks then monthly for 3 months and results will be reported to QAPI at least quarterly.  
*Resident 17 and 18 will be monitored by the staff development or the designee for appropriate blood sugar testing and any other residents who have blood sugar testing. Random audits of those residents will be done by the staff development coordinator or designee three times weekly for four weeks and then monthly for three months & the results will be brought to the QAPI committee quarterly. (continued page 29.)*

*\* 11/13/14  
S/S/D/D/H/M/F*

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| F 441  | <p>Continued From page 28</p> <p>identified procedure to prevent infections for two of two sampled residents (17 and 18).</p> <p>*Complete personal care (Foley catheter care and handling of dentures) following aseptic (clean) practices for two of two sampled residents (2 and 8).</p> <p>*Complete consecutive dressing changes for one of one sampled resident (2) by one of one registered nurse (RN) B using aseptic technique on one of one sampled resident (2).</p> <p>*Administer a medication by an alternative method using a procedure to prevent possible contamination for one of one sampled resident (13).</p> <p>*Following manufacturer's instructions on steps for cleaning two of two whirlpool tubs.</p> <p>Findings include:</p> <p>1. Interview on 10/8/14 at 1:00 p.m. with the infection control nurse revealed:</p> <p>*She agreed they had limited policies and procedures in place regarding infection control practices.</p> <p>*They used the reference "Being a Long-Term Care Nursing Assistant" for steps needed to complete care for residents.</p> <p>*She had been working on several additional policies and procedures.</p> <p>*She had not completed any monitoring of the staff on infection control practices such as hand washing, dressing changes, residents' personal care, or whirlpool tub cleaning.</p> <p>*The quality assurance committee was kept informed of the facility's infection rates.</p> <p>*Documentation tools to identify patterns of infections in individual residents or in groups of residents had not been utilized.</p> <p>Surveyor: 32355</p> | F 441   | <p>Resident 2 and 8 will be monitored by the staff development or the designee for appropriate procedures for Foley catheter care and for any other residents who have a Foley catheter. Random audits of those residents will be done by the staff development coordinator or the designee three times weekly for four weeks and then monthly for three months and the results will be brought to the QAPI committee quarterly.</p> <p>scjddp/mf</p> <p>* Resident 2 will be monitored by the staff development coordinator or designee for appropriate dressing change procedures and any other residents who have dressing changes. The staff development or designee will audit dressing changes once weekly for four</p> |   |

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| F 441  | <p>Continued From page 29</p> <p>2. Observation on 10/7/14 from 11:10 a.m. through 11:30 a.m. of licensed practical nurse (LPN) A revealed:</p> <p>*Without washing or sanitizing her hands she had:</p> <ul style="list-style-type: none"> <li>-Put on a clean pair of gloves and entered resident 17's room.</li> <li>-Retrieved a plastic container sitting on the resident's bedside dresser.</li> <li>-Opened the plastic container and retrieved the necessary supplies to check the resident's blood sugar.</li> <li>-Held the resident's left hand and checked her blood sugar.</li> <li>-Placed the blood glucose meter (blood sugar testing equipment) back inside of the plastic container, removed her gloves, and left the room.</li> <li>-Retrieved a pen off the medication cart, opened the treatment assessment record (TAR), and documented the resident's blood sugar results.</li> </ul> <p>*Moved the medication cart down the hall to resident 18's room.</p> <p>*Without washing or sanitizing her hands she had:</p> <ul style="list-style-type: none"> <li>-Put on a clean pair of gloves and entered his room.</li> <li>-Repeated the same observation as above.</li> </ul> <p>*Prior to removing her gloves an unidentified staff member approached LPN A and requested a pair of hearing aides for another resident.</p> <p>*With those gloved hands she had:</p> <ul style="list-style-type: none"> <li>-Retrieved a set of keys from a pocket attached to her top.</li> <li>-Opened the medication cart and retrieved a small box, opened the box, and removed two hearing aides.</li> <li>-Given the hearing aides to the unidentified staff member to deliver to another resident.</li> </ul> <p>*She removed her gloves and documented</p> | F 441   | <p>Weeks and then monthly for three months and the results will be brought to the QAPI committee quarterly.<br/>SJSDDO4/MF</p> <p>* Resident 13 will be monitored by the staff development coordinator or designee for the appropriate procedure for G-tube medication administration. The staff development coordinator or designee will audit medication administration weekly for four weeks and then monthly for three months and the results will be brought to the QAPI committee quarterly.<br/>SJSDDO4/MF</p> |   |

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| F 441  | <p>Continued From page 30</p> <p>resident 18's blood sugar level in the TAR.<br/>*She moved the medication cart down to another hallway and entered an unidentified resident's room.<br/>*She had not been observed washing or sanitizing her hands during the above observation.</p> <p>Interview on 10/8/14 at 3:15 p.m. with the infection control/staff development nurse revealed:<br/>*She would have expected LPN A to have washed or sanitized her hands:<br/>-Prior to assisting the residents with their blood sugar testing.<br/>-After the completion of checking both of the residents' blood sugar levels.<br/>-Between delivering care to different residents.<br/>*She confirmed the above observations had not been done in a sanitary process.<br/>*She agreed there had been potential for cross-contamination from one resident to another.<br/>*She had no documentation or audits available to support the monitoring of the staff while assisting residents with their blood sugar testing.<br/>*Her observations and auditing process had been random, and any concerns were addressed at the time of the observation.</p> <p>The provider did have a policy and procedure for blood sugar testing.</p> <p>Surveyor: 33265<br/>3. Observation on 10/8/14 at 7:30 a.m. with resident 8 and CNA G during urine catheter care revealed she:<br/>*Removed dirty gloves and put on clean gloves four times without washing her hands in between.</p> | F 441   |   |   |

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| F 441  | <p>Continued From page 31</p> <p>*Went from soiled to clean tasks twice without changing gloves.</p> <p>*Had not emptied the Foley catheter bag completely before attempting to disinfect it with a bleach and water solution.</p> <p>-Approximately fifty cubic centimeters (liquid measure) of urine remained in the bag.</p> <p>*Had not rinsed the measuring container after urine was emptied from it.</p> <p>Interview on 10/8/14 at 1:00 p.m. with the infection control nurse regarding the above observation revealed she agreed:</p> <p>*The hands should have been washed after gloves were removed and before clean gloves were put on.</p> <p>*When going from a task where gloves might have touched soiled objects to a task involving clean supplies or clothing gloves should be removed, hands washed, and clean gloves put on.</p> <p>*The Foley catheter bag should have been empty of urine before doing the bleach and water rinse solution.</p> <p>*The container should have been rinsed after use.</p> <p>Review of the provider's 7/17/14 and untitled policy and procedure on maintaining an indwelling urinary drainage system (such as a Foley catheter) revealed correct hand hygiene and Standard Precautions were to be used by all trained staff handling and maintaining catheters.</p> <p>Review of the provider's 9/27/12 Using Urinary Catheter Leg Drainage Bag policy and procedure revealed when the drainage bag was unhooked it should have been emptied of urine before the bag was rinsed with a bleach and water solution.</p> | F 441   |   |   |

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| F 441  | <p>Continued From page 32</p> <p>Surveyor: 32355</p> <p>4. Observation on 10/7/14 from 4:05 p.m. through 4:15 p.m. of CNAs C and D during a transfer and personal care with resident 2 revealed:</p> <p>*Both CNAs had entered the resident's room to assist him with getting out of his bed.</p> <p>*Without washing or sanitizing their hands they had put on a clean gloves.</p> <p>*With those gloved hands they had:</p> <p>-Assisted the resident to sit on the edge of his bed.</p> <p>-Placed the EZ Way mechanical lift (device to assist with transfers) in front of the resident.</p> <p>-Assisted him with the placement of the sling around his waist and secured the safety strap around his legs.</p> <p>-CNA D used the mechanical lift remote to help assist the resident into the standing position.</p> <p>-Moved him into the bathroom, placed him in front of the toilet, pulled down his pants and incontinent brief (disposable undergarment).</p> <p>-CNA D again used the remote control and lowered him down to sit on the toilet.</p> <p>*The CNAs recognized he did not have his dentures in.</p> <p>*CNA D retrieved the denture cup holder containing his dentures from a shelf above the bathroom sink and handed it to CNA C.</p> <p>*CNA C removed the resident's dentures from the cup and attempted to put them in his mouth. He refused to have them put in.</p> <p>*CNA C replaced the dentures back inside the cup and handed it back to CNA D.</p> <p>*CNA D put the denture cup on the shelf.</p> <p>*Both of the CNAs removed their dirty gloves, put on a clean pair of gloves, and finished assisting him off the toilet and into his wheelchair.</p> <p>*They removed their gloves and sanitized their</p> | F 441   |   |   |

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| F 441  | <p>Continued From page 33 hands at that time.</p> <p>Interview on 10/8/14 at 3:20 p.m. with the infection control/staff development nurse revealed she would have expected:</p> <ul style="list-style-type: none"> <li>*Hand washing to have occurred prior to assisting the resident with any type of care.</li> <li>*Gloves to have been removed, hands washed or sanitized, and clean gloves put on prior to working with the resident and his dentures.</li> <li>*She had no documentation or audits to support the monitoring of the staff during personal care.</li> </ul> <p>Review of the provider's undated Handwashing policy and procedure revealed:</p> <ul style="list-style-type: none"> <li>*It contained information on proper technique for handwashing.</li> <li>*No information was found to guide the staff on when to wash or sanitize their hands.</li> </ul> <p>Surveyor: 33265</p> <p>5. Observation and interview on 10/8/14 at 10:05 a.m. with CNA E during cleaning of the whirlpool tub on the 100-200 wing following use revealed:</p> <ul style="list-style-type: none"> <li>*A resident had been incontinent (leaking of urine or bowel movement from the body) of bowel while in whirlpool.</li> <li>*She rinsed the tub with water and scrubbed the sides and bottom with a long handled brush while the rinse water was running.</li> <li>*She put the plug in drain and pushed the button for the disinfectant to pool in the base of the tub.</li> <li>*She had no idea how much disinfectant to put in. She stated she put in enough for a "small pool" of disinfectant solution to form in front of the tub over the drain.</li> <li>*She sprayed the sides of the tub with another disinfectant in a spray bottle and stated it was the same disinfectant even though the name was</li> </ul> | F 441   |   |   |

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| F 441  | <p>Continued From page 34<br/>different on the bottle.</p> <p>*She would let the disinfectant sit on the tub surface for five to ten minutes if the resident had not been incontinent in the tub.</p> <p>*Since a resident had been incontinent in the tub, she filled the tub with water and let the jets run for fifteen minutes.</p> <p>*That was the standard procedure for incontinence contamination and for residents with known infections.</p> <p>-There was no contact time (time disinfectant was to be on the surface to kill germs) as the tub was immediately filled with water.</p> <p>*She drained the tub after letting the jets run for fifteen minutes.</p> <p>*She rinsed off the tub surfaces and then ran the jets until only clear water came through them.</p> <p>*She stated after all baths were completed she would also do a two minute cycle of air to dry the tub, but she had not started the air jets for that cleaning.</p> <p>Interview and review of tub manufacturer's cleaning instructions on 10/8/14 at 1:00 p.m. with the infection control nurse concerning whirlpool tub cleaning revealed:</p> <p>*She agreed with the steps CNA E had done to clean the whirlpool between residents.</p> <p>*She was not sure those steps were the same as the steps suggested by the tub manufacturer.</p> <p>*She had not been able to identify the amount of disinfectant the manufacturer had suggested should be used for cleaning the tub.</p> <p>*She could not give a reason for the CNA spraying on a disinfectant instead of using a long handled brush and using the disinfectant pooled in the tub to scrub the surfaces.</p> <p>*She thought the disinfectant spray and the bottled tub manufacturer's disinfectant were the</p> | F 441   |   |   |

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| F 441  | <p>Continued From page 35</p> <p>same product even though there was a different name on the spray bottle.</p> <p>-Upon review of the disinfectants she agreed the spray disinfectant and tub manufacturer disinfectant were not the same product.</p> <p>*She had not been able to identify why the tub was immediately filled with water and run for fifteen minutes when contaminated. That was the way they had cleaned the tub following possible contamination.</p> <p>*Upon review of the manufacturer's instructions she agreed the suggested steps for cleaning the whirlpool tub were not being followed.</p> <p>*She had not been aware the staff were not running a drying cycle after each tub use as the manufacturer had suggested.</p> <p>*She had not completed monitoring of staff completing whirlpool tub cleaning between residents or at the end of the day.</p> <p>*She stated they had no policy or procedure other than the manufacturer's Safe Operation &amp; Daily Maintenance Instructions.</p> <p>Review of the undated Penner Manufacturing Safe Operation &amp; Daily Maintenance Instructions for Cascade Premier and Elite Premier Bathing Systems revealed after every use the tub should have:</p> <p>*Been rinsed with the warmest water possible to remove visible tissue, residue, or fluids from the resident's tub using the shower sprayer.</p> <p>*Rinse water should have been drained, and the plug then placed in the drain.</p> <p>*One to one and a half gallons of disinfectant should have been released into the foot of the tub.</p> <p>*Tub surfaces should have been scrubbed with the disinfectant and a long handled brush, and the solution allowed to sit on the surface for ten</p> | F 441   |   |   |

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| F 441  | <p>Continued From page 36</p> <p>minutes.</p> <p>*The drain should have been removed.</p> <p>*Tub should have been rinsed with clean water using the shower sprayer.</p> <p>*The rinse jet button should have been pressed and held until clear water ran from all of the air jets.</p> <p>*A final rinse should have been done of all tub surfaces using the shower sprayer.</p> <p>*Air jets should have been allowed to run for thirty seconds. That final step pushed rinse water out of the air jets. When the last bath of the day was done the blowers should have ran for two minutes.</p> <p>*The final step should have been a visual check of the tub surfaces.</p> <p>Surveyor: 16385</p> <p>6. Observation and interview on 10/9/14 at 8:30 a.m. in the 100-200 wing bath area of CNA E cleaning the Cascade Premier Sit-Bath System whirlpool tub revealed:</p> <p>*She had pressed and held the disinfectant jet button to run disinfectant through the jet system and out all air jets and down the drain for approximately fifteen seconds.</p> <p>*She then sprayed the tub surface and lift chair with Classic Whirlpool Disinfectant Cleaner.</p> <p>*She stated she would have left the disinfectant on for five to ten minutes and then rinsed the entire tub.</p> <p>Review of the Classic Whirlpool Disinfectant Cleaner revealed the product should have remained on the surface and wet for ten minutes.</p> <p>Review of the Cascade Premier Sit-Bath System cleaning instructions revealed:</p> | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 37</p> <p>*3. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness.</p> <p>*4. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tub surfaces with the shower sprayer.</p> <p>*5. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain.</p> <p>*6. On the Aqua-Aire Tubs, press and hold the Disinfectant Jets Button. As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub.</p> <p>*7. Using the long-handled brush, thoroughly scrub all interior surfaces of the tub, swivel lift, and reservoir with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes.</p> <p>*8. Remove the plug from the drain.</p> <p>*9. Rinse the Lift or Transfer, and the tub's interior surfaces thoroughly with the shower sprayer."</p> <p>Surveyor: 32355<br/>7. Observation on 10/8/14 from 8:50 a.m. through 9:10 a.m. of RN B changing both of resident 2's dressings to both of his feet revealed she:<br/>*Put on gloves prior to entering the resident's room.<br/>*Had not washed or sanitized her hands prior to putting on those gloves.<br/>*Took the treatment assessment records (TAR) and two packages of guaze and laid them directly</p> | F 441   |   |                      |   |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                 |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>435080</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>10/09/2014</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>BETHESDA OF BERESFORD</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>606 W CEDAR<br/>BERESFORD, SD 57004</b>                             |                      |   |
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| F 441  | Continued From page 38<br>on his bedside table without a barrier (protection between clean and dirty surfaces).<br>*Retrieved keys out of her jacket pocket.<br>*Went back to the treatment cart and opened that cart with those keys.<br>*Retrieved a bottle of wound cleanser and relocked the treatment cart.<br>*Returned to his room and placed the bottle of wound cleanser directly on his bedside table.<br>*Touched the controls on his bed to raise it up into a higher position.<br>*Picked up a mat laying on the floor in front of his bed, folded it, and placed it in another part of the room.<br>*Removed the footpedals for his wheelchair off the bedside table and laid them on the floor.<br>*Removed his socks.<br>*Retrieved an un-opened package of gauze from her jacket pocket.<br>*Opened and sprayed the gauze with wound cleanser.<br>*Cleansed several wounds on his toes on both feet using the same gauze.<br>*Disposed of the soiled gauze.<br>*Retrieved another un-opened package of gauze from her jacket pocket.<br>*Opened the package and used the same piece of clean gauze to dry all of his wounds to all his toes.<br>*Removed her soiled gloves and put on a clean pair. She had not sanitized or washed her hands after removing the soiled gloves.<br>*Retrieved two packages of Betadine swabs from her pocket.<br>*Opened those packages, removed two Betadine swabs, and used them to clean several wounds on his toes.<br>*Opened the two packages of gauze laying directly on his bedside table. | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 39</p> <ul style="list-style-type: none"> <li>*Retrieved the gauze inside of those packages and wrapped both of his feet with them.</li> <li>*Searched in her pocket and retrieved a roll of tape.</li> <li>*Used that tape to secure the bandages to both of his feet. When she had completed that she laid the roll of tape directly on his bedside table.</li> <li>*Opened his dresser drawer and touched the clothing in the drawer with those soiled gloves.</li> <li>*Took a pair of socks from his drawer and put them on his feet.</li> <li>*Removed her gloves and sanitized her hands.</li> <li>*Put the roll of tape back into her pocket.</li> <li>*Opened the treatment cart and put the wound cleanser inside with several other dressing supplies.</li> <li>*She did not wipe off the wound cleanser bottle before putting it in with the clean supplies. Thus creating a possibility of cross-contamination.</li> </ul> <p>Interview at that time with RN B revealed she:</p> <ul style="list-style-type: none"> <li>*Had not recognized the above observation as an unsanitary process.</li> <li>*Agreed she had created the potential for cross-contamination to the resident creating a risk of infection to his wounds.</li> <li>*Confirmed the tape and wound cleanser were used for multiple residents.</li> <li>*Could not remember the last time she had been observed by the infection control/staff development nurse during a dressing change.</li> </ul> <p>Interview on 10/8/14 at 3:25 p.m. with the infection control/staff development nurse revealed she:</p> <ul style="list-style-type: none"> <li>*Confirmed the above dressing change had not been done in a sanitary process.</li> <li>*Agreed RN B had created the potential for cross-contamination to his wounds allowing for</li> </ul> | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 40<br/>the risk of infection.<br/>*Had no documentation or audits to support any observations of the staff doing a dressing change.</p> <p>Review of the provider's 9/14/06 Non-Sterile Dressing Change policy revealed:<br/>*Purpose: "To prevent infection and promote healing of wound."<br/>*Policy: "It is the policy of [provider name] to safely perform nursing functions in compliance with State and Federal Regulations and with practices/procedures that are widely accepted across the nursing industry."<br/>*Hands were to have been washed prior to assembling any supplies required to do the dressing change.<br/>*Gloves were to have been put on after getting after after removing the old dressing.<br/>*Clean gloves were to have been put on before cleaning the wound.</p> <p>8. Observation on 10/7/14 at 1:55 p.m. of licensed practical nurse (LPN) A administering medication to resident 13 through a gastrostomy tube (g-tube) (tube in the stomach used for feeding and nutrition) revealed she:<br/>*Put on gloves prior to entering the resident's room.<br/>*Had not washed or sanitized her hands prior to putting on those gloves.<br/>*Got a plastic container and a syringe from the resident's bedside table.<br/>*Opened the syringe and laid it directly on a dirty fly swatter.<br/>*Took the plastic container, went into the bathroom, turned on the water faucet, and put water in the container.<br/>*Returned to the resident and placed the container on the bedside table.</p> | F 441   |   |                      |   |

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| F 441  | <p>Continued From page 41</p> <p>*Opened the tip of the resident's g-tube and inserted the syringe to check for placement.<br/>*Administered the medication.<br/>*Removed her gloves and with those ungloved and unsanitized hands she:<br/>-Turned on the water faucet in the bathroom.<br/>-Took apart the syringe and rinsed it under the water.<br/>-Replaced the syringe inside of the plastic container, put them on the resident's bedside dresser, and left the room.<br/>*Did not wash or sanitize her hands.</p> <p>Interview at that time with LPN A revealed she:<br/>*Had not recognized the above process as an unsanitary practice until being interviewed.<br/>*Agreed her technique had been unsanitary and placed the resident at risk for cross-contamination.</p> <p>Interview on 10/8/14 at 3:35 p.m. with the infection control/staff development nurse confirmed the above process had been unsanitary. It had placed the resident at risk for cross-contamination and infection.</p> <p>Review of the provider's 9/12/06 General Rules for Medication Administration policy revealed:<br/>*Purpose: "To safely administer medications to the residents of [provider name]."<br/>*Policy: "[Provider name] expects all employees who administer medications to apply professional standards of care during the process of medication administration."</p> <p>Review of the provider's undated and untitled procedure for Administering Medication by Nasogastric (tube inserted through the nose and the stomach) tube revealed:</p> | F 441   |   |                      |   |

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| F 441  | Continued From page 42<br>*The provider had used the above as their reference for administering medications through a g-tube.<br>*The provider had been unable to supply a policy and procedure specific to administering medications through a g-tube.<br>*That procedure directed the staff to:<br>-Perform hand hygiene prior to organizing the equipment.<br>-Put on clean gloves prior to checking for placement and administering the medication.<br>-Remove their gloves and perform hand hygiene after the medication had been administered. | F 441   |   |                      |   |

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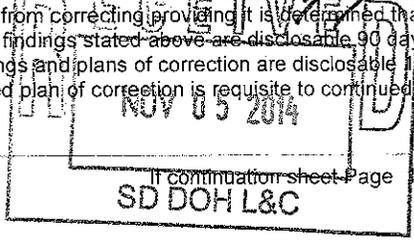
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| K 000 | <p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 14180<br/>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/8/14. Bethesda of Beresford was found in compliance with 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p> | K 000 |  |  |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br><i>[Signature]</i> | TITLE<br><i>Administrator</i> | (X6) DATE<br><i>11/03/2014</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.



South Dakota Department of Health

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| S 000 | Initial Comments<br>Addendums noted with an asterisk per 11/7/14 telephone to facility administrator. SCSDDOH/MF   | S 000 | <b>S 206 - PERSONNEL-TRAINING</b><br><br>The 2015 and subsequent educational calendars will have scheduled educational in-serve training for staff on residents with unique needs. *to include TBI & ALS. SCSDDOH/MF<br><br>An in-service training on Hospice will be conducted on 11/06/2014 during an All Staff meeting.<br><br>The Staff Development Coordinator or designee will monitor training results monthly and report to the QAPI Committee quarterly* until determined by the committee to be resolved. SCSDDOH/MF |                         |
| S 206 | 44:04:04:05 PERSONNEL-TRAINING<br><br>The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects:<br>(1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff;<br>(2) Emergency procedures and preparedness;<br>(3) Infection control and prevention;<br>(4) Accident prevention and safety procedures;<br>(5) Proper use of restraints;<br>(6) ...Resident rights;<br>(7) Confidentiality of...resident information;<br>(8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms;<br>(9) Care of...residents with unique needs; and<br>(10) Dining assistance, nutritional risks, and hydration needs of...residents.<br><br>...Additional personnel education shall be based on facility identified needs. | S 206 |  | * 11/8/14<br>SCSDDOH/MF |

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

*[Signature]*

STATE FORM

RECEIVED

Administrator

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If continuation sheet of 3

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| S 206 | <p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:<br/>Surveyor: 33265<br/>Based on record review and interview, the provider failed to ensure all staff received required training on the unique needs of residents during the last twelve months. Findings include:</p> <p>1. Review of the provider's educational calendar for the last twelve months revealed there had been no required training for all staff members regarding residents with unique needs.</p> <p>Interview on 10/8/14 at 1:00 p.m. with the infection control nurse revealed she:<br/>*Was responsible for scheduling and preparation of educational training within the facility.<br/>*Agreed there had been no education regarding residents with unique needs.</p>           | S 206 |   |                                  |
| S 294 | <p>44:04:07:04 Written Menus</p> <p>Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as prescribed by each...residents's physician. Each menu must be written at least one week in advance. Each planned menu must be approved, signed, and dated by the dietitian for all facilities. Any menu changes from month to month must be reviewed by the dietitian and each menu must be reviewed and approved by the dietitian at least annually where applicable. Each menu as served must meet the nutritional needs of the...residents in accordance with the physician's orders and the Recommended Dietary Allowances of the National Research Council.. Tenth Edition, 1989. Records of menus</p> | S 294 | <p><b>S 294 - Written Menus</b></p> <p>Bethesda's Dietician will review any/all menu changes on the food substitution logs since April, 2014, and review her results with Bethesda's Dietary Manager.</p> <p>The Dietician will also review and approve any/all menu changes on the food substitution log monthly and discuss any concerns with the Dietary Manager.</p> <p>The Dietary Manager or designee will audit the food substitution log weekly to ensure compliance and report findings to the QAPI Committee quarterly *until determined by the committee to be resolved.</p> | <p>* 11/18/14<br/>SCLSDDHIMF</p> |

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| S 294 | <p>Continued From page 2</p> <p>as served must be filed and retained for 30 days.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by:<br/>Surveyor: 32335<br/>Based on record review and interview, the provider failed to have the registered dietician (RD) review the food substitution logs on a monthly basis for three straight months. Findings include:</p> <p>1. Review of the provider's menu substitution form revealed:<br/>*Food substitutions had occurred:<br/>-Twice in April 2014.<br/>-Three times in May 2014<br/>-Five times in June 2014.<br/>-Four times in July 2014.<br/>*The RD had reviewed the form on 7/24/14.<br/>*She had not reviewed it monthly.</p> <p>Interview on 10/8/14 at 1:10 p.m. with the dietary manager revealed the RD had not been consistently reviewing the food substitutions.</p> <p>The RD was not available for interview at that time.</p> <p>The director of nursing was also unavailable at that time as she was on a leave of absence from the facility.</p> | S 294 |  |  |
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