

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

ORIGINAL

PRINTED: 09/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/14/2014
NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005		
(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	INITIAL COMMENTS	F 000			
F 167 SS=C	<p>Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/12/14 through 8/14/14. Bethany Home - Brandon was found not in compliance with the following requirements: F167, F221, F248, F250, F280, F309, F323, F371, and F441.</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation and interview, the provider failed to ensure the results of the most recent survey were available in four of four neighborhoods (Plum Creek, Willow Wood Way, Cottonwood Court, and Maple Valley). Findings include:</p> <p>1. Observation on 8/14/14 from 7:30 a.m. through 8:30 a.m. revealed: *A posted sign by the nurses station in Plum Creek, Willow Wood Way, and Maple Valley</p>	F 167	<p>F 167: On 9/2/2014, the DON wrote a policy regarding posting survey results in Bethany Home Brandon. The DON has ensured that a copy of the complaint survey conducted on 11/7/2013 is in the binders in all four of the resident neighborhoods in each of the entertainment centers. The most recent surveys were placed in all four binders by 9-4-2014.</p> <p>New signs were posted at the time of the 2014 survey on each of the neighborhoods to state "Survey results are available in the binder on the entertainment center on each resident neighborhood". The DON will place any additional surveys in these binders as they occur. The DON or her designee will complete a QA Monitor monthly beginning 9/15/2014 to ensure the</p>	9/15/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Jane Mullickson, Administrator, Emergency Permit Holder

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 30 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	Continued From page 1. neighborhoods stated "Survey results available upon request." *No sign regarding the survey results had been posted in the Cottonwood Court neighborhood. *A three-ring binder in the entertainment center in each of the neighborhoods labeled "2013 Surveys." *All four three-ring binders had a copy of the recertification survey dated 9/5/13. *A complaint survey had been conducted on 11/7/13 which was not in the binder. Interview on 8/14/14 at 10:00 a.m. with the administrator revealed she was not sure why the posted sign was worded that way. She agreed the sign should have stated where the survey results were so individuals would not have to request the survey results. She had not been aware the three-ring binders had not included the November 2013 survey.	F 167	F 167 contd: most recent survey results are in the binders. The DON will report findings to the quarterly QA meetings for as long as the QA committee deems necessary.		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Preceptor: 26180 Based on observation, record review, interview, and policy review, the provider failed to assess on an ongoing basis for one of one resident's (16) use of a lap tray (a detachable tray) in a geriatric chair (geri-chair) (a type of wheelchair) to show	F 221	F 221 The DON and Neighborhood Leader B reviewed the Physical Restraints policy on 9/4/2014 and found it to be accurate. Neighborhood Leader B and Physical Therapy (PT) assessed resident #16 on 9/5/2014 to ensure proper use of geri-tray. It was determined that the geri-tray is not being utilized as a physical restraint. A quarterly review by the interdisciplinary team, which includes PT, will be conducted to ensure that the geri-tray is not being utilized as a restraint. The use of the geri-tray will be reviewed and discussed with the interdisciplinary team at the care conference and as needed per Bethany	9/30/14	

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F 221	Continued From page 2 whether or not it was a restraint. Findings include: 1. Random observations from 8/12/14 through 8/14/14 revealed resident 16 was sitting upright in a geri-chair with a lap tray on it. Review of the above resident's medical record revealed: *She used the lap tray as a positioning device and to assist her with dining. *No assessments had been done since the one in August 2012. Interview on 8/14/14 at 9:00 a.m. with the director of nursing and neighborhood leader B revealed they had not thought they needed to update assessments for the lap tray on a regular basis. Review of the provider's 8/11/12 Physical Restraint Policy revealed: *"Physical restraints are any method or physical or mechanical device, material, or equipment attached to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body; this includes.....geri chairs with trays." *A Restraint Assessment form and a Restraint Reduction Assessment form. Review of the provider's inservice meeting on restraints from 5/29/14 revealed geri-chairs/recliners and lap trays were physical restraints.	F 221	F 221 contd: policy. Beginning 9/15/2014, the care conference staff, including PT, will assess all residents at their quarterly care conferences to ensure they are free from physical restraints. The Restraint Assessment Form and Restraint Reduction Assessment form will continue to be used as a monitor for Resident #16 and all residents who are utilizing an object which could be a restraint (side rails, seat belt, etc.). Beginning 9/15/2014, The DON or her designee will complete a monthly audit to ensure all residents with a potential restraint have the two aforementioned forms completed. The DON or her designee will report findings to the quarterly QA committee for as long as the committee deems necessary. If it is determined that the geri-tray or other physical restraint is being utilized as a restraint, Bethany will assess, obtain a Physician's order, including rationale for use of the restraint, as well as permission from resident/POA. The use of the restraint will be included in the care plan. The interdisciplinary team and all nursing staff was inserviced on 9/11/2014 regarding this policy.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with	F 248		9/25/14

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F 248	<p>Continued From page 3</p> <p>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: Surveyor: 26180 Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (1 and 2) in the memory care unit (Maple Valley) received activities based on their assessed needs and interests. Findings include:</p> <p>1. Interview on 8/12/14 at 8:30 a.m. with licensed practical nurse (LPN) A revealed: *Resident 1 had been in isolation (restricted to his room) for several months on and off. -He was currently being treated for clostridium difficile (C-Diff) (a drug resistant infection of the bowels causing diarrhea). -Until his diarrhea stopped, he needed to stay in his room per their isolation policy. *They did not really have a scheduled program of activities in the memory care unit during the day. *The activities in the memory care unit just depended on how things were going in the unit at the time. *"We just come up with something and do it."</p> <p>Random observation on 8/12/14 from 8:10 a.m. through 6:30 p.m. of resident 1 in the memory care unit revealed he: *Was in his room and had contact isolation procedures in place. -Was not allowed to leave his room due to the isolation. -Did not have a roommate.</p>	F 248	<p>F 248</p> <p>On 9/10/2014, Activity Coordinator reviewed and revised 248 contd: the policy, "Maple Valley Recreation Programming". The policy reads, as follows:</p> <p>a. Structured activity programming will occur on Maple Valley at least twice per day. Each activity will be lead/ facilitated by nursing staff or volunteers, once in the morning and once in the afternoon or evening.</p> <p>b. If nursing staff is unable to facilitate activity program, they will communicate with activity coordinator daily to ensure consistent care is provided. In the absence of activity coordinator, memory care staff will communicate with neighborhood leaders daily to ensure activities are held.</p> <p>c. A Maple Valley-specific schedule will be distributed by the activity coordinator monthly. Staff is to post this schedule where it is visible to residents and families.</p> <p>Regarding Resident #1: Resident passed away on 9/10/2014. Resident #2's care plan was</p>		

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F 248	<p>Continued From page 4</p> <p>*Had staff enter his room to: -Take him to the toilet. -Administer medications. -Respond to his TABs alarm (alerts staff when the resident attempts to stand up without assistance). -Bring his meals.</p> <p>*Sat in his recliner in front of the television and had no other activity offered to him. *Responded eagerly when he saw someone in the hall and said "Come in" when this surveyor was close to his room doorway.</p> <p>Interview on 8/12/14 at 6:15 p.m. with registered nurse E revealed there was not a scheduled program of activities in the memory care unit in the evening.</p> <p>Review of resident 1's 6/12/14 Minimum Data Set (MDS) assessment revealed he enjoyed music, people, pets, and spiritual programs.</p> <p>Review of resident 1's August 2014 activity record revealed he had participated in Mind Stimulation and visits daily.</p> <p>Interview on 8/12/14 at 2:00 p.m. with LPN A revealed they had a busy day with residents exhibiting behaviors. They were not able to do any activities with resident 1. She stated that was how it sometimes went there, and they just did not have the time to do the activities. They normally tried to do activities, but today it had not worked out.</p> <p>Interview on 8/13/14 at 3:30 p.m. with a family member of resident 1 revealed: *They visited several times a week. *He had been in isolation three times since March</p>	F 248	<p>F 248 contd: updated by the Activity Coordinator on 9/10/2014 to ensure activities needs are being met.</p> <p>"Communicating Needs of a Resident on Isolation Status", policy, which includes the Activity Coordinator, written by Social Services and implemented on 9/10/2014.</p> <p>Education provided on 9/11/2014 by DON and Activities Coordinator for Maple Valley staff regarding appropriate use of neighborhood space and proper documentation of activities. Education provided regarding mind-stimulating programming, including television, on 9/11/2014 by DON and Activities Coordinator.</p> <p>Beginning 9/15/2014, Activity Coordinator will complete QA monitors three times per week for two months to ensure Maple Valley Recreation Programming policy is followed and proper documentation is occurring. Results will be reported by the Activity Coordinator or her designee to the</p>		

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F 248	<p>Continued From page 5</p> <p>2014, all of which were for several weeks at a time.</p> <p>*They were worried about him emotionally, because he was isolated.</p> <p>*They had noticed he was getting more agitated.</p> <p>*They had spent several hours during their visits, and there was very little activity occurring.</p> <p>*They had asked staff to do activities with him since he was confined to his room. However when they came to visit he was sitting in his recliner alone watching television.</p> <p>Interview on 8/13/14 at 4:00 p.m. with an unidentified certified nursing assistant (CNA) revealed Mind Stimulation was watching the television.</p> <p>2. Random observation of resident 2 on 8/12/14 from 8:10 a.m. until 6:30 p.m. in the memory care unit revealed:</p> <p>*She sat in a reclining position in the day room.</p> <p>*She sat about four feet from a large screen television that was to the right of her.</p> <p>-Her chair was turned about 10 degrees in the direction of the television, but she was not facing it.</p> <p>-The television was on and tuned to a current news program.</p> <p>-No one was watching the television, but two other residents sat nearby and were sleeping.</p> <p>*At that same time someone began playing the piano, and the residents were encouraged to sing.</p> <p>-No one encouraged resident 1.</p> <p>-At one point she appeared to be singing with the piano, but the television continued to be on and the volume conflicted with the piano playing.</p> <p>*She was only moved from that position to go to</p>	F 248	<p>F 248 contd: QA committee quarterly and will continue as long as the committee deems necessary. Programming guide to be provided by Activity Coordinator to Maple Valley Staff on 9/25/2014 with instructions for alternative, and additional, activities that can be offered to residents when appropriate.</p> <p>Inservice training provided on 9/11/2014 by the DON and Activities Coordinator regarding turning off the television if the television conflicts with group events.</p> <p>Activity Coordinator to present at all-staff meeting on 9/25/2014 regarding appropriate activities for Maple Valley and for all residents. Presentation will specifically include the aforementioned items as well as involving as many residents as possible in activities, utilizing the care plan for resident likes and interests, and documenting when resident participates or refuses.</p>	

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F 248	<p>Continued From page 6</p> <p>her room to be toileted throughout the day. *She refused to eat lunch. *After lunch they returned her to the recliner, and she laid there with her eyes closed until they started to get residents ready for supper. *At 5:15 p.m. on 8/12/14 they took her to her room to be toileted. She then sat at the table in the dining room to have her supper meal.</p> <p>Further observation of resident 2 on 8/13/14 revealed she continued to be placed in the recliner in the day room with her feet up. The television was on. No staff were observed to encourage her participation in the small group activity or to assist her outside into the courtyard. Conversations with the resident were geared toward task completion such as eating or taking her to her room to toilet.</p> <p>Review of resident 2's 7/22/14 MDS activity preferences revealed: *It was very important for her to have: -Books, newspapers, and magazines to read. -Music. -Animals/pets. -Keep up with the news. -People. -Favorite activities. -Fresh air. *Additional information revealed she was visually impaired (blind).</p> <p>Review of resident 2's 5/22/14 care plan revealed: *Her favorite activities included reading, watching tennis, news programs or soap operas, and attending spiritual events. *Staff were supposed to offer her a variety of activity types and locations to increase interests.</p>	F 248		
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F 248	Continued From page 7 Review of resident 2's August 2014 activity record revealed she: *Observed Mind Stimulation (television). *Visited. *Observed sensory, relaxation activity. 3. Interview on 8/14/14 at 9:30 a.m. with the activity coordinator revealed: *Resident 1 had some activities that he could have done independently if they assisted setting him up with that. *She confirmed activities were not occurring in the memory care unit as they were intended to have been. *It was the expectation the CNAs would also do activities with the residents as well as provide the personal care to them. *She had not monitored the level of activity resident 1 had received while he was in isolation. *Staff should have been going into the residents' rooms twice a day to offer activities. *If staff did not have time to do the activities they should have communicated that to the activity department. Review of the provider's August 2014 Memory Care Recreation Programming policy revealed: *"The purpose of this policy is to ensure that residents in Maple Valley are offered an ongoing activity program which includes emotional, social, and physical, spiritual and intellectual programming." *Structured activity programming would be offered on the memory care unit twice per day.	F 248		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250	F 250 On 9/9/2014, Social Services wrote a policy, "Communicating Needs of a Resident on Isolation". The policy reads, as follows: The infection control nurse will determine when it is medically necessary for a resident to be on isolation precautions.	10/1/14

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F 250	<p>Continued From page 8</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, record review, and job description review, the provider failed to ensure two of two sampled residents (1 and 2) in the memory care unit (Maple Valley) received social services based on their assessed needs. Findings include:</p> <p>1. Random observation on 8/12/14 from 8:10 a.m. through 6:30 p.m. in the memory care unit of resident 1 revealed the resident: *Was in his room and had contact isolation procedures in place. -Was not allowed to leave his room due to the isolation . -Did not have a roommate. *Had staff enter his room to provide him with daily care needs. *Had family visitors at various times.</p> <p>Interview on 8/12/14 at 8:30 a.m. with licensed practical nurse A revealed: *Resident 1 had been in isolation (restricted to his room) for several months on and off. *He was currently being treated for clostridium difficile (C-Diff) (a drug resistant infection of the bowels causing diarrhea).</p> <p>Review of resident 1's 6/12/14 Minimum Data Set (MDS) assessment revealed he:</p>	F 250	<p>F 250 contd: The infection control nurse or her designee will call a meeting within 72 hours of the resident going on isolation status. This meeting will include representatives from Dietary, Nursing, Social Services, Activities/Chaplaincy, Environmental Services, and any other representatives deemed necessary by the infection control nurse or her designee</p> <p>The meeting will be conducted to ensure each discipline is meeting residents' designated needs. Records will be reviewed and team will assign departments and individuals to meet specific needs of resident.</p> <p>Review of resident on isolation's chart will be conducted at the resident's quarterly care conference and more often, if the infection control nurse deems necessary.</p> <p>After Isolation meeting (as per the aforementioned policy), SS will meet with resident on isolation and will, together with resident, staff and family, determine frequency of visits based on individual need. Beginning 9/23/2014, this consultation will be documented in progress notes.</p> <p>Regarding Resident #1: Resident was removed from isolation precautions on 8/14/2014 and died on 9/10/2014. Social services contacted and spoke with family of Resident #1 regarding their concerns on 9/8/2014. As of 9/23/2014, there are no residents on isolation status.</p>	

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F 250	<p>Continued From page 9</p> <ul style="list-style-type: none"> *Felt down and depressed. *Felt bad about himself. *Had decreased energy. *Had thoughts of being better off dead. <p>Interview on 8/13/14 at 3:30 p.m. with a family member of resident 1 revealed:</p> <ul style="list-style-type: none"> *They visited several times a week. *He had been in isolation three times since March 2014, all of which were for several weeks at a time. *They were worried about him emotionally, because he was isolated. *They had noticed he was getting more agitated. *They had spent several hours during their visits, and there was very little activity occurring. *They had asked staff to do activities with him since he was confined to his room. However when they came to visit he was sitting in his recliner alone watching television. <p>Review of resident 1's social services notes revealed:</p> <p>*6/16/14-"He is currently in isolation and needing to stay in his room, sometimes is okay with this and other times is not and becomes agitated. He does take an anti-anxiety medication."</p> <p>*There was no documentation of any direct services provided by social services to provide support to the resident or his family, to assist staff in managing his behaviors, or assisting in helping the family resolve their concerns.</p> <p>Interview on 8/13/14 at 4:00 p.m. with the social services coordinator regarding resident 1 revealed:</p> <ul style="list-style-type: none"> *The resident had been in isolation several times for periods of time. *She had not documented any contact she had 	F 250	<p>F 250 contd: Beginning 9/29/2014 the DON or her designee will monitor that Isolation Meeting occurred and that Social Services met with resident and documented meeting. These monitors will occur monthly and results will be reported to the QA committee by DON or her designee. This will continue for as long as the committee deems necessary.</p> <p>On 9/10/2014, Social Services reviewed "Psycho-Social Assessments and Charting" policy and "Social Services Care Planning" policy and found them to be appropriate.</p> <p>On 9/10/2014, Social Services reviewed and revised the "In-House Social Services Referrals" policy. The policy now reads, as follows: Social Services Referral forms are kept at each nursing station and within the Social Services office.</p> <p>The master of this form is kept by the secretary/receptionist.</p> <p>If staff becomes aware of a social service need, staff will complete a Social Service Referral Form.</p> <p>The completed form can be placed in the Social Services mailbox, or in the suggestion box near the front desk, or given directly to Social Services in person.</p> <p>Follow up by Social Services Department will be noted in the progress notes within one week.</p> <p>The "Social Service Referral" form was distributed by Social Services to each neighborhood on 9/23/2014. In-</p>		

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F 250	<p>Continued From page 10 with the resident or family during that time. *She occasionally stopped in his room but had no planned interventions or contacts with him.</p> <p>2. Random observation of resident 2 on 8/12/14 from 8:10 a.m. in the memory care unit through the supper meal revealed: *She spent most of the day sitting in the recliner in the day room with her eyes closed. *When you spoke to her she would answer. *She became upset with staff when they wanted her to take her medications, and she refused to take them. *She stated "I do not want to take any more medications. I do not want to eat. I do not want to live here anymore."</p> <p>Review of resident 2's diagnoses revealed she was depressed and had anxiety.</p> <p>Review of resident 2's physician's orders revealed an order had been given on 11/15/13 for her to be seen by a mental/behavioral health agency.</p> <p>Review of the above mental/behavioral health agency progress notes revealed on 4/17/14 those services were discontinued, because the resident had refused their services.</p> <p>Review of resident 2's 7/18/14 annual MDS assessment revealed she had: *Little interest in doing things. *Felt down and depressed. *Difficulty sleeping or slept too much. *Little energy and a poor appetite. *Trouble concentrating. *Felt bad about herself. *Thought she would be better off dead.</p>	F 250	<p>F 250 contd: service training provided to nursing by Social Services on 9/23/2014 and 9/25/2014. Beginning 10/1/2014, Social Services will audit monthly to ensure the Social Service Referral forms are available on each resident neighborhood and report findings to the QA committee quarterly for as long as the committee deems necessary. Beginning 10/1/2014 Social Services will complete an audit monthly, indicating that the any referrals have been addressed and documented in the resident's progress notes. The monthly audit reports will be presented by Social Services to the quarterly QA committee for as long as the committee deems necessary. Regarding Resident #2: Social Services made contact with resident #2 on 9/9/2014 and is meeting weekly with resident until the October 2014 care conference. At that time, the team and any family attending the care conference will determine future frequency of these visits. The visits will continue as long as the team deems necessary. Social Services will review all current MDSs. Any resident who scores 14 or above on the PHQ-9 will be reassessed and Social Services will determine and document frequency of visits and if any other interventions are necessary with DON input. Findings will be reported to the QA committee</p>		

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F 250	Continued From page 11 Review of resident 2's social services notes revealed: *There had been no follow-up by the social worker since she had refused the behavioral health services. *There was no documentation of supportive services having been provided to the resident. *The only social services notes were the quarterly summary reviews. Review of the provider's 12/12/06 Social Worker job description revealed "The Social Worker is generally responsible for assisting the Director in the identification of social, psychological, and emotional strengths and needs of the residents on an individual basis, and the provision of services to meet such needs and fulfill such strengths. -This will be done through liaison between the resident and their family, facility staff and community."	F 250	F 250 contd: quarterly for as long as the committee deems necessary. Neighborhood Leader will audit Social Services documentation monthly to ensure residents with PH-9 score of 14 or above are receiving direct services by Social Services to support them and their family. Findings will be reported by the DON or designee to the QA committee quarterly for as long as the committee deems necessary.	
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280	F 280 On 10/1/2014, the DON reviewed the Plan of Care policy and added the following: All care plans are to be reviewed/ updated quarterly, as needed, and upon significant change. The DON or Neighborhood Leader will review a minimum of three care plans a week to ensure accuracy and compliance. The DON will report findings to the	10/3/14

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F 280	<p>Continued From page 12</p> <p>the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to update residents' care plans related to: *Seat belt positioning for one of one sampled resident (5) utilizing a seat belt. *Visual impairment for one of one sampled resident (2) with visual problems. Findings include:</p> <p>1. Observation on 8/12/14 at 8:30 a.m. in the dining room on Willow Wood Way revealed resident 5 was seated in a wheelchair with a seat belt secured around the lower portion of his body.</p> <p>Review of resident 5's 1/15/14 care plan revealed: *The use of the seat belt for positioning when up was to continue until the appointment on 2/26/14 with a rehabilitation center. *There was no documentation as to whether the use of seat belts was to have continued or not after the appointment on 2/26/14.</p> <p>Surveyor: 26180 2. Review of resident 2's 7/18/14 annual Minimum Data Set assessment revealed she had:</p>	F 280	<p>F 280 contd: quarterly QA committee for as long as the Committee deems necessary. Resident #5 has passed away since the survey.</p> <p>The care plan for Resident #2 has been updated by the Neighborhood Leader, Social Services, and the Activity Coordinator. Activities detailed how to assist the resident with activities due to visual impairment, the Neighborhood Leader addressed how to assist her with meals with the visual impairment, and Social Services updated how staff is to assist her with mood and behavioral issues.</p> <p>On 9/11/2014 our DON provided training to the Interdisciplinary Team and nursing staff regarding this policy.</p>	

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F 280	<p>Continued From page 13</p> <ul style="list-style-type: none"> *Little interest in doing things. *Felt down and depressed. *Difficulty sleeping or slept too much. *Little energy and a poor appetite. *Trouble concentrating. *Felt bad about herself. *Thought she would be better off dead. *Her activity preferences revealed it was very important for her to have: <ul style="list-style-type: none"> -Books, newspapers, and magazines to read. -Music. -Animals/pets. -Keep up with the news. -People. -Favorite activities. -Fresh air. *Additional information revealed she was visually impaired (blind). <p>Review of resident 2's 11/1/13 psychiatric consultation revealed "Patient continues to have nihilistic [skeptical/baseless] viewpoint and perseverates [dwells on] her blindness."</p> <p>Interview on 8/12/14 at 9:30 a.m. with licensed practical nurse A revealed resident 2 had severe visual impairment.</p> <p>Review of resident 2's 7/18/14 Care Area Assessment revealed:</p> <ul style="list-style-type: none"> *Nutrition was an area that triggered, because she had a weight loss and was on a mechanically altered diet. -The functional problems that were assessed that affected her ability to eat were visual problems and an inability to perform activities of daily living (eating) without significant physical assistance. -Depression was a condition that could effect her appetite. 	F 280	<p>d.</p> <p>e.</p> <p>f.</p>	

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F 280	<p>Continued From page 14</p> <p>-She was on an antipsychotic (mental disorder) medication.</p> <p>*Behavioral symptoms was an area that triggered, because behaviors had occurred four to six days.</p> <p>-The resident was considered an immediate threat to herself.</p> <p>-She had a visual impairment.</p> <p>*Visual impairment was an area that triggered because her vision was impaired, and she had mood problems along with dementia (memory impairment).</p> <p>-She had difficulty seeing television, reading material of interest, and participating in activities of interest because of that impairment.</p> <p>Review of resident 2's care plan revealed:</p> <p>*Her favorite activities included reading, watching tennis, news programs or soap operas, and attending spiritual events.</p> <p>*Staff were to offer her a variety of activity types and locations to increase interests.</p> <p>*The care plan had not addressed:</p> <p>-How staff were to assist her with activities with the visual impairment.</p> <p>-How staff were to assist her with meals with the visual impairment.</p> <p>-How staff were to assist her with her mood and behavioral issues.</p> <p>Interview on 8/14/14 at 9:45 a.m. with the director of nursing revealed resident 2's care plan should have addressed how staff were to assist the resident adapt with her visual impairment.</p> <p>Interview on 8/14/14 at 9:45 a.m. with the activity director revealed the care plan had not thoroughly addressed how the staff intervened with her vision problem.</p>	F 280		

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F 280	Continued From page 15 Review of the provider's August 2013 Plan of Care policy revealed: *The plan of care was to have identified problems, approaches, goals, and the services necessary to assist the resident in attaining the highest possible level of functioning. *No identification of when the care plan should have been updated.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Preceptor: 26180 Based on record review, interview, and policy review, the provider failed to update and combine the hospice plan of care with the provider's plan of care for two of two sampled hospice residents (11 and 13). Findings include: 1. Review of resident 11's entire medical record revealed an admission date of 6/10/13 and a 7/12/14 hospice start date. Review of resident 11's 7/16/14 comprehensive care plan revealed: ** (Resident) is currently receiving hospice	F 309	F309 On 9/4/2014, the DON reviewed and revised the Plan of Care for Hospice Residents. The policy now reads: a. An initial, individualized plan of care is developed upon admission to hospice. The plan is evaluated upon admission, quarterly, and with significant change. If the patient is admitted to hospice upon admission to Bethany Home Brandon, the initial care plan is documented on the care plan Kardex, which is also known as the "Initial Plan of Care". If a current resident is admitted to hospice, their care plan will be updated to integrate the plan of care for hospice. b. An interdisciplinary plan of care is developed within seven (7) days after completion of the comprehensive MDS assessment and is based upon the identification of the resident's condition and needs. The plan of care identifies problems, approaches, goals, and the services necessary to assist the resident in attaining the highest practicable level of functioning. c. Bethany will ensure that the Plan of Care for each resident receiving hospice service integrates the hospice company's plan of care with Bethany's plan of care.	9/30/14

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F 309	<p>Continued From page 16</p> <p>services through [name of Hospice agency]", and "Coordinate with hospice services." *Under nutritional status: "Set up help staff assist as needed. Staff are feeding most of the time. Hospice staff here over noon." *There was no further reference regarding the resident's care to specify responsibility between hospice and the provider.</p> <p>Interview on 8/14/14 at 9:00 a.m. with the director of nursing and neighborhood leader B regarding the above resident revealed: *Neither had thought they needed to combine both care plans for a hospice resident into a comprehensive one. *They agreed that should have been done.</p> <p>Surveyor: 26180 2. Review of resident 13's medical record revealed: *He was admitted on 12/15/12. *An order for a hospice consultation had been received at the time of admission. *He was currently receiving hospice services.</p> <p>Review of resident 13's care plan with a review date of 8/1/14 revealed: *He had a terminal prognosis. -This care plan problem was started on 1/22/13. -The goal was to maintain his comfort. -The interventions were to "work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met." *The care plan had not addressed any specifics of what hospice was responsible for.</p> <p>3. Interview on 8/14/14 at 9:30 a.m. with</p>	F 309	<p>F 309 contd: Integrating hospice services into the Plan of Care aids in maintaining the patient's highest practicable physical, mental, and psychosocial well-being. The services that are provided for these residents include Chaplaincy, Nursing, CNA and Social Work. The hospice staff provides care in addition to Bethany staff and Bethany will coordinate with the hospice company regarding changes in resident condition, such as medication changes, level of consciousness, pain management, skin condition, communication with family, and any other pertinent information. In addition to the aforementioned items, Bethany and the hospice company will collaborate quarterly and as needed regarding resident care.</p> <p>d. The care plan will explain which services are provided by Bethany and which services are provided by the hospice company. In the absence of the hospice company, Bethany will meet the resident's needs, as outlined in the care plan.</p> <p>e. Care conferences including all disciplines (Bethany staff and contracted hospice service personnel) will be held on or near day fourteen (14), on a quarterly basis, after each hospitalization, and as scheduled. The resident and/or family members are invited to attend and encouraged to participate in this care conference.</p> <p>a. f. All those attending the Care Conference are asked to sign an attendance sheet. The nursing staff in-serviced on 9/11/2014 regarding the updates to this policy. On 9/15/2014, the Neighborhood Leader or</p>		

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F 309	Continued From page 17 registered nurse/neighborhood leader C revealed: *They were unaware they needed to incorporate the specifics of hospice into the care plans. *They thought it would have been sufficient to place the hospice care plan in the care plan book. Review of the provider's August 2013 Hospice Plan of Care policy revealed: *They would "Ensure that each Hospice patient's written Plan of Care includes both the most recent hospice plan of care and a description of the services furnished by [name of facility] to attain or maintain the hospice patient's highest practicable physical, mental, and psychosocial well-being." *It had not addressed how they integrated the hospice plan of care with the provider's plan of care.	F 309	F 309 Contd: designee will complete a monthly care plan audit to ensure hospice integration is included in the care plan and is correct and current to meet the needs of the resident for all residents currently receiving Hospice services as well as all residents admitted to Hospice. The Neighborhood Leader or designee will report finding to the quarterly QA Committee for as long as the Committee deems necessary.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and policy review, the provider failed to ensure two of two utility rooms with hazardous chemicals in them were secured in two of three units (Maple Valley and Willow Wood Way). Findings include:	F 323	F 323 On 9/4/2014, the DON and Environmental Services Director reviewed the Storage of Cleaning Products Policy. No revisions were made. On 9/8/2014, the door locks into all utility rooms were changed to auto-lock door handles. These doors can be unlocked only with a key and always automatically lock. A key, kept by staff, must be used to access these areas.	9/15/14	

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F 323	<p>Continued From page 18</p> <p>1. Observation on 8/12/14 at 8:10 a.m. and on 8/14/14 at 11:00 a.m. in Maple Valley, the secured memory care unit, revealed an unlocked door labeled "Utility." Further observation revealed: *That door opened into a small hallway with two unlocked doors. -On the back of the first door were two signs stating those doors were to remain locked at all times. *The two doors in that small hallway were labeled for clean and soiled utilities. *The soiled utility room had multiple bottles of cleaning supplies. *The cleaning supplies were all labeled with warning labels regarding the contents having hazardous chemicals in them. *Residents in that unit were able to access these doors without difficulty.</p> <p>Interview on 8/12/14 at 8:30 a.m. with licensed practical nurse (LPN) A revealed all the residents who resided in Maple Valley had a cognitive impairment (memory impaired).</p> <p>Interview on 8/14/14 at 11:00 a.m. with LPN A revealed those doors leading to the utility rooms should not have been left unlocked.</p> <p>Surveyor: 33265</p> <p>2. Observation on 8/12/14 at 8:05 a.m. and at 10:22 a.m., and on 8/13/14 at 7:10 a.m. revealed the door to the utility room on Willow Wood Way had been unlocked. Inside the door was another door that opened into a soiled utility room that contained the following chemicals: *Betco Kling - toilet cleaner, one partially used quart container and one full quart container. The</p>	F 323	<p>F 323 Contd: Starting 9/15/2014, the Environmental Supervisor will complete a QA monitor on all four utility doors weekly for three months then monthly thereafter to ensure that the door locks are working properly. The Environmental Supervisor will report the results to the QA quarterly committee as long as the Committee deems necessary. The doors were locked effective 9/8/2014 and all staff was in-serviced on 9/11/2014.</p>	

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F 323	Continued From page 19 label stated it was corrosive and would cause eye, skin, and digestive burns. *Betco Best Bet - a liquid cream cleaner, one partially used quart container. The label stated it was "harmful if swallowed" and caused burns. *Betco AF79 Concentrate - disinfectant, one partially used quart container and one full 0.67 gallon container. The label stated it was "hazardous to humans" and caused irreversible eye damage. *Chlortox bleach-one full gallon. The label stated it was harmful if swallowed. 3. Interview on 8/14/14 at 10:35 a.m. with the director of nursing revealed she: *Had placed signs and a photo on the back of each utility room door to remind staff to keep the doors locked at all times. *Would have expected the utility room doors to have been locked at all times. Review of provider's 9/5/13 Storage of Cleaning Products policy revealed cleaning products that were not in use were to have been stored behind closed and locked doors.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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	F 371	F 371 On 9/8/2014, the DON and the Dietary Manager reviewed the Handling of Ready-to-Eat-Foods Policy and added: a. Gloves don't need to be worn when completing dietary- activities if ready-to-eat foods are not handled. This includes passing trays and pouring liquids. b. After gloves removed, must wash hands.	9/30/14

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F 371	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, and policy review, the provider failed to ensure: *Handwashing and glove use occurred appropriately when dishing food and passing food trays during meal service for two of two meals observed. *Kitchen equipment was kept in a sanitary condition on four of four neighborhoods (Plum Creek, Willow Wood Way, Cottonwood Court, and Maple Valley). *Sanitary conditions were maintained in one of one main kitchen. *Juices were labeled and dated when opened in two of four neighborhoods (Plum Creek and Maple Valley). *Trash containers were covered when not in-use for one of four neighborhoods (Maple Valley). *Serving utensils were covered in transit from the main kitchen to the first neighborhood for one of two meal service observations. *Portable steam tables were kept clean for one of two neighborhoods (Maple Valley). Findings include:</p> <p>1. Observation on 8/12/14 of the noon meal service in the four neighborhoods revealed: *Gloves had been worn by dietary aide I while dishing up residents' plates in each of the four neighborhoods. -He changed his gloves for each neighborhood dining room meal service. -He had not been observed touching any ready-to-eat (RTE) foods. *Care specialists with gloves on delivered residents their meal plates in Plum Creek and</p>	F 371	<p>F 371 contd: On 9/8/2014, Dietary Manager and DON reviewed and revised the Bethany Employee Handbook regarding food and drink in the work area policy. It now states: Absolutely NO FOOD OR DRINK is allowed in the employee's work area, including but not limited to food prep and service areas, and anywhere that contamination by blood or other potentially infectious materials may occur. In-service training provided by DON and Dietary Manager to all nursing and dietary staff regarding this on 9/11/2014. The Dietary Manager will complete a QA monitor at least three times per week for three weeks and monthly thereafter to ensure there is no food or drink in the food prep and service area. Beginning 9/15/2014, the Dietary Manager or her designee will report findings to the Quarterly QA committee for as long as the committee deems necessary. On 9/3/2014, the dirty can opener was cleaned. On 9/8/2014, the Dietary Manager reviewed the cleaning procedure for kitchen utensils and found it to be correct. The utensils, including the can opener, are to be washed daily and as needed. DON and dietary manager provided in-service training to staff on 9/11/2014 regarding this policy and process. Beginning 9/15/2014, Dietary Manger and DON will complete random QA monitors to ensure can openers and kitchen utensils are clean. These QA monitors will be completed at least three times per week for three weeks and monthly thereafter, with results reported to quarterly QA committee by the DON and Dietary Manager. These audits will continue as long as the QA committee deems necessary. On 9/14/2014 The DON and the Dietary</p>	
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F 371	<p>Continued From page 21 Cottonwood Court neighborhood dining rooms. -They had not been observed touching any RTE foods.</p> <p>Observation on 8/12/14 of the evening meal service in the four neighborhoods revealed: *Dietary aide J in Maple Valley neighborhood washed his hands and turned the faucet off with his clean hands. *Care specialists with gloves on delivered residents their meal plates in Plum Creek and Cottonwood Court neighborhood dining rooms. -They had not been observed touching any RTE foods.</p> <p>Interview on 8/13/14 at 3:45 p.m. with the dietary manager confirmed gloves would not have to be worn by any staff members unless they were touching RTE foods. Dietary aide J should have turned the faucet off with a clean towel.</p> <p>Review of the provider's Policy and Procedure for Handling Ready-to-Eat Foods dated July 2012 revealed: *Use proper hand washing procedure prior to handling food. *Wear gloves when handling ready-to-eat foods.</p> <p>2. Random observation in the following areas revealed: *On 8/12/14 at 8:15 a.m. of the main kitchen there was a dirty can opener and an opened bottle of soda pop *On 8/12/14 at 5:10 p.m. the serving utensils were uncovered on top of the transit cart that took food from the main kitchen to the neighborhoods. *On 8/13/14 at 2:00 p.m.: -Dirty microwaves in Willow Wood Way, Cottonwood Court, and Maple Valley</p>	F 371	<p>F 371 contd: Manager wrote a policy for covering trash a. cans in the dish room. The policy states: The bins in the Bethany kitchenettes must be covered with a lid anytime staff is not placing items into the bins. In order to ensure compliance, beginning 9/15/2014, DON will complete random QA monitors at least three times per week for three weeks and monthly thereafter, and the DON will report results to quarterly QA committee. These audits will continue as long as the QA committee deems necessary. Inservice training regarding this policy provided on 9/11/2014 by the DON. On 9/8/2014, The DON and the Dietary Manager wrote a policy for Cleaning the Steam Tables. The policy is, as follows:</p> <ol style="list-style-type: none"> Nursing staff must sanitize the stainless steel serving counter on the steam tables with Quat 146 or another Bethany-approved food sanitizer after every meal. After the evening meal, the entire steam table is to be cleaned and sanitized by nursing staff. To clean the steam table, use hot water and dish soap. Water must be drained from the steam tables after the evening meal by the nursing staff on the evening shift. Allow the steam table to cool for at least 30 minutes and then remove any food residue/ debris. Wipe the bins with hot water & dish soap. The table-top warmers must be unplugged & left to cool for at least 30 min. Nursing staff must wash out with a hot water & dish soap & place in the cupboard when dry. Beginning 9/15/2014, DON will complete random observation audits at least three times per week for three weeks and monthly thereafter to ensure compliance with the Cleaning the Steam Tables policy. 	

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F 371	Continued From page 22 neighborhoods. -Unlabeled and undated juice containers in Maple Valley and Plum Creek neighborhoods refrigerators. -A dirty and uncovered trash container in Maple Valley neighborhood. Interview on 8/13/14 at 4:00 p.m. with the dietary manager confirmed the above areas had not been clean and sanitary. Surveyor: 26180 2. Observation in Maple Valley (memory care unit) revealed in the kitchen area there was a portable steam table. That steam table had a build-up of lime and a white milky scum floating in the water. Interview on 8/12/14 at 2:00 p.m. with licensed practical nurse A revealed she was unsure who was responsible for cleaning the portable steam table. She thought it was the dietary department. She acknowledged the steam table was dirty. Interview on 8/13/14 at 9:00 a.m. with dietary aide I who came into the Maple Valley unit revealed the nursing department was responsible for cleaning the portable steam tables. Interview on 8/13/14 at 11:00 a.m. with the dietary manager revealed the nursing department was supposed to clean the portable steam tables. She was unaware that staff did not know who was responsible for cleaning that.	F 371	F 371 contd: The DON will report to the findings to the quarterly QA committee for as long as the committee deems necessary. Inservice training regarding this policy provided on 9/11/2014 by the DON. On 9/4/2014, The DON & the policy on Dietary Manager reviewed & revised the Maintaining Proper Refrigeration Safety. a. Added: Every food and drink which is not in its original container must be labeled and dated with a tape label. On 9/5/2014, the Dietary Director wrote a policy for Covering of Serving Utensils When Transported. The policy reads: Staff will use suitable covering when transporting clean dishes and clean serving utensils outside the kitchen and or units. Use suitable covering when transporting clean dishes & serving utensils outside the units and kitchen areas. Coverings include: lids, enclosed cart, plastic wrap, foil. Beginning 9/15/2014, Dietary manager will complete a minimum of 2 random QA monitors at least 3 times per week for 3 weeks and monthly thereafter, with results reported to quarterly QA committee by the dietary manager. These audits will continue for as long as the QA committee deems necessary. The DON reviewed and revised the hand washing policy on 9/8/2014, and we revised it to say go to the nearest sink to wash hands. All staff inservice regarding proper hand washing and glove use provided on 9/11/2014 by the DON. Dietary Manager will provide personal inservice and return demonstration by 9/15/2014 to Dietary Aide J regarding handwashing and glove use. Dietary Aide I is no longer employed at Bethany.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	<p>Continued From page 23</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265</p>	F 441	<p>F 441</p> <p>On 9/3/2014, the DON reviewed and revised the "Policy and Procedure for Non-Sterile Dressing Change" to ensure the first step is to wash hands and to define "clean field" Revisions include:</p> <p>a. Obtain and set up equipment on a clean field by using a chux or a disposable sterile drape.</p> <p>b. Remove soiled dressings and discard according to facility policy</p> <p>Neighborhood Leader B provided personal in-service with return demonstration on 9-11-14 to Nurse F to ensure understanding and compliance with the revised policy and procedure for non-sterile dressing change. Inservice training provided by DON regarding appropriate glove use with a non-sterile dressing change provided to Nurse F and all nursing staff on 9/11/2014.</p> <p>A minimum of three random observation audits by the Neighborhood Leader B on nurse F and other nurses will be completed on non-sterile dressing changes a minimum of three times a week for three weeks starting 9/8/14. The neighborhood leader will complete a minimum of three random</p>	9/9/14

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F 441	<p>Continued From page 24</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <ul style="list-style-type: none"> *Appropriate glove use and barrier (sterile plastic backed sheet) for a dressing change for one of two sampled residents (10). *Appropriate disinfection of glucometers (machine used to measures level of sugar in blood) for two of two sampled residents (10 and 17) with diabetes. *Appropriate glove use during two insulin injections for two of two sampled residents (10 and 17) with diabetes. *Appropriate hand hygiene and disinfection of equipment following care for two of three sampled residents (1 and 10) on isolation. *Documentation of the cleaning of a resident room with bleach according to physician's orders for one of one sampled resident (1) on isolation. <p>Findings include:</p> <p>1. Observation on 8/14/14 from 7:10 a.m. through 7:30 a.m. on Willow Wood Way with registered nurse (RN) F revealed:</p> <ul style="list-style-type: none"> *Supplies were taken into resident 10's room and placed on a visibly soiled bedside stand. No barrier was placed on the bedside table to prevent the contamination of items placed there. *After she assisted the resident with the bedpan, she removed her gloves, washed her hands, put on new gloves, and then exited room by touching the door with her gloved hand to retrieve another pair of clean gloves for later use. *The clean gloves were placed on top of an eyeglass case and tissue box. *She then continued using the same gloves to remove the soiled dressing. *Following the removal of the soiled dressing she removed her gloves, washed her hands, and put on the gloves that were laying on the eyeglass 	F 441	<p>F 441 contd: observation audits per month thereafter with personal in-services to be provided as needed. Regarding glucometers, policy to clean and disinfect the blood glucose meter reviewed and revised by DON on 9/8/2014. Revisions include:</p> <ul style="list-style-type: none"> a. Each diabetic resident has their own glucose monitor. b. The device is to be cleaned and disinfected between each glucose check. When a resident is on isolation, nurse will ensure there are bleach wipes outside the resident room. Then, wrap the EPA-approved wipe around the glucose test strip insertion site for at least four minutes. c. Omit: Glucose meter is shared in a multi-resident setting... All residents will have their own glucose meter effective 9-9-14. The DON will provide a personal inservice with return demonstration to Nurse H regarding the glucometer policy and proper glove usage before 9/22/2014. Three random observation quality assurance monitors per week for three weeks then weekly thereafter to ensure compliance with the policy will be completed by the DON. The DON will report findings to the QA committee for 	

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F 441	<p>Continued From page 25 case and tissue box.</p> <p>*Using those gloves she moved the clean cotton swabs and plastic dressing to the bed. No barrier was placed on top of the linen to prevent contamination of clean supplies.</p> <p>*Following the cleaning of the wound she picked up the measuring device from the bedside table and placed the same side that had been sitting on the soiled bedside table onto the skin directly next to the open wound.</p> <p>*After placing the sterile dressing over the open wound she asked certified nursing assistant (CNA) G if her hands were clean. CNA G had gloves on and had been assisting by supporting the resident lying on her side. Her hands were on the lower half of the resident's right side on bare skin. She said her hands were clean, and RN F proceeded to have CNA G place her right hand over the sterile dressing to hold it in place while she secured the dressing with plastic adhesive sheeting.</p> <p>Interview on 8/14/14 at 10:35 a.m. with the director of nursing revealed she:</p> <p>*Expected there to be gloves available in the residents' rooms for employee use.</p> <p>*Had not been aware of barrier use for supplies during a dressing change.</p> <p>*Expected gloves to be changed before going from a possibly soiled area to a clean area or dressing.</p> <p>Review of the provider's 7/12/14 Contact Precautions policy revealed staff working with residents under contact precautions needed to ensure hands had not touched potentially contaminated surfaces or items in resident rooms to avoid transfers of pathogens to other residents or environments.</p>	F 441	<p>F 441 contd: as long as the Committee deems necessary. Personal in-servicing with return demonstration by Neighborhood Leaders provided to Nurse F and H will be conducted by 9/12/14 regarding appropriate glove use and standard precautions during insulin injections. A group in-service will be provided to all nurses regarding appropriate glove use and standard precautions during insulin injections on 9-11-14. There will be three random observation audits weekly for three weeks then one per week thereafter. The DON will report the results to the QA committee quarterly for as long as the committee deems necessary. The DON reviewed the glove usage for nursing staff policy on 9/9/2014 and found it to be correct. The Neighborhood Leader provided a personal inservice to Nurse H regarding proper glove usage and the DON provided inservice to all nursing staff on 9/11/2014 regarding proper glove usage. Inservice training provided to all nursing staff by DON on 9/11/2014. The hand hygiene policy was reviewed by DON on 9/8/2014 and added the following:</p>	

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F 441	<p>Continued From page 26</p> <p>2a. Observation on 8/12/14 on Willow Wood Way revealed at 11:15 a.m. RN F completed a blood glucose (sugar) test on resident 10. During that observation she did the following :</p> <ul style="list-style-type: none"> *Found there were no disinfectant wipes to disinfect the glucometer on the isolation cart outside of resident 10's room. *Walked with the soiled glucometer to resident 7's room where a container of disinfectant wipes was on the isolation cart outside of the room. *Wiped off the glucometer with the disinfectant wipes for twenty-two seconds instead of the four minutes identified in the manufacturer's instructions. *Placed the glucometer on the treatment cart. *Said the glucometer needed to dry for four minutes. <p>b. Observation on 8/12/14 on Willow Wood Way revealed:</p> <ul style="list-style-type: none"> *At 4:56 p.m. RN H completed a blood glucose test on resident 17. During that observation she did the following: <ul style="list-style-type: none"> -Wiped off the glucometer with the disinfectant wipes for eighteen seconds instead of the four minutes identified in the manufacturer's instructions. -Placed the glucometer on the treatment cart. -Said the glucometer needed to dry for four minutes. *At 5:05 p.m. RN H completed a blood glucose test on resident 10. During that observation she did the following: <ul style="list-style-type: none"> -Found there were no disinfectant wipes to disinfect the glucometer on the isolation cart outside of resident 10's room. -Walked with the soiled glucometer to resident 7's room where a container of disinfectant wipes was 	F 441	<p>F 441 contd: a. Go to the nearest sink to wash hands.</p> <p>All staff inservice training by the DON regarding hand hygiene provided on 9/11/2014 to ensure compliance with the hand hygiene policy. Inservice training regarding proper hand washing and glove use provided on 9/11/2014 by the DON.</p> <p>The DON provided nursing staff inservice education on 9/11/2014 regarding the proper Contact Precautions Policy. On 9/15/2014, DON will audit nursing staff knowledge of this policy. The DON will Bethany currently does not have any residents on isolation; therefore, DON will audit their knowledge by giving the staff a test on this topic. There will be three audits weekly for three weeks then one per week thereafter. The DON will report the results to the QA committee quarterly for as long as the committee deems necessary. On 9/8/2014, the Neighborhood Leaders stocked all rooms with a box of gloves. The Neighborhood Leaders or their designee will ensure the rooms are appropriately stocked with boxes of gloves. Random audits will occur for residents on isolation, three times per week for three weeks and once</p>		

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F 441	<p>Continued From page 27</p> <p>on the isolation cart outside of the room.</p> <p>-Wiped off the glucometer with the disinfectant wipes for twenty seconds instead of the four minutes identified in the manufacturer's instructions.</p> <p>-Placed the glucometer on the treatment cart.</p> <p>-Said the glucometer needed to dry for four minutes.</p> <p>c. Interview on 8/14/14 at 10:35 a.m. with the director of nursing revealed she: *Expected there would be disinfectant wipes available where needed. *Had not realized the manufacturer's instructions stated the item being disinfected should be kept wet with the disinfectant solution for four minutes.</p> <p>Review of the provider's 8/13/14 Cleaning and Disinfecting the Glucose Monitor policy revealed staff were to have cleaned the monitor with a soft cloth bleach wipe and allowed the glucose monitor to air dry for four minutes.</p> <p>Review of the manufacturer's instructions on the label of the disinfectant wipes revealed the object being disinfected needed to stay wet with the disinfectant solution for four minutes.</p> <p>3. Observation on 8/12/14 on Willow Wood Way during medication administration rounds revealed: *At 11:15 a.m. RN F had given an insulin injection to resident 10 in the resident's room without wearing gloves. *At 4:56 p.m. RN H had given an insulin injection to resident 17 in the resident's room without wearing gloves. *At 5:05 p.m. RN H had given an insulin injection to resident 10 in the resident's room without</p>	F 441	<p>F 441 contd: per week thereafter in order to ensure the rooms are stocked. Results will be reported to the QA Committee and audits will continue as long as the committee deems necessary.</p> <p>Personal inservicing regarding hand hygiene and glove use with return demonstration provided to CNA G by Neighborhood Leader B on 9/12/2014. Random observation audits will take place three times per week for three weeks and then weekly to ensure compliance. Results will be reported to the QA Committee and audits will occur as long as the committee deems necessary.</p> <p>The Contact Precautions Policy was reviewed by the DON on 9/9/2014 and it was found to be accurate.</p> <p>Handwashing policy was updated to read: "Go to the closest sink to wash your hands when soiled".</p> <p>The Neighborhood Leader provided a personal inservice with return demonstration to CNA D on 9/11/2014 regarding proper hand washing, with emphasis on going to the nearest sink, and the contact precautions policy.</p> <p>Inservice training will be provided by the DON on 9/11/2014 regarding the Contact Precautions</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 28 wearing gloves.</p> <p>Interview on 8/14/14 at 10:35 a.m. with the director of nursing regarding the above observations revealed she: *Expected gloves to be available in the residents' rooms for employee use. *Expected nurses to wear gloves when giving an injection as there might be contact with blood.</p> <p>Review of the provider's 8/14/14 Glove Usage for Nursing Staff policy revealed gloves should have been worn when touching bodily tissues, mucous membranes, or broken skin.</p> <p>4. Observation on 8/12/14 at 5:05 p.m. of RN H revealed: *She had taken a blood glucose reading of resident 10 in resident 10's room. *She left the resident's room and found no disinfectant wipes on the isolation cart outside of resident 10's room. *While wearing the soiled gloves she opened each drawer in the isolation cart outside the room. *She went to resident 7's room and set the soiled glucometer on the top of the isolation cart there while wearing those soiled gloves. *Neither the drawer handles of the isolation cart outside of resident 10's room or the top of the isolation cart outside of resident 7's room were disinfected following the above observations.</p> <p>Interview on 8/14/14 at 10:35 a.m. with the director of nursing revealed she: *Expected there to be disinfectant wipes available where needed. *Had not realized the manufacturer's instructions for the disinfectant wipes identified a four minute</p>	F 441	<p>F 441 contd: Policy and the Handwashing Policy. There will be a minimum of three random nursing staff observation audits weekly for three weeks then one per week thereafter to ensure proper hand washing and compliance with contact precautions policy. The DON will report the results to the QA committee quarterly for as long as the committee deems necessary.</p> <p>Reviewed Resident #1's medical record on 8-15-14 and the isolation was discontinued. Reviewed and revised the physician's order policy to state: that treatments and special orders will be entered on the TAR to ensure proper follow-through. By placing items on the TAR this required the staff nurse to document its completion. Inservice training will be provided to the nurses on 9-11-14 on this policy to ensure compliance. Beginning 9-15-14 DON and neighborhood leaders with audit all physician orders weekly to ensure that the treatments and special orders are entered into the TAR completely and that corresponding documentation is in place. DON and neighborhood leaders will submit findings to the quarterly QA</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005	
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F 441	<p>Continued From page 29</p> <p>wet contact time (time item being disinfected was to be kept wet with the disinfectant solution). *Expected any surface or equipment possibly contaminated by gloves used for resident care to be disinfected immediately.</p> <p>Review of the provider's 8/11/12 Contact Precautions policy revealed staff were to remove gloves right before leaving the resident's room and wash hands immediately.</p> <p>Surveyor: 26180 5. Observation on 8/12/14 at 10:00 a.m. with resident 1 revealed: *He was in a room with contact isolation procedures (to prevent the spread of an infection) in place. *CNA D and an unidentified CNA were assisting him to the toilet to have a bowel movement. -The CNAs were gloved and gowned. *After he had finished going to the bathroom CNA D wiped and cleaned up his bottom. *CNA D: -Then left the resident with the other CNA to finish up his care. -Came out of the resident's bathroom and prepared to exit the resident's room. -Removed her gown and gloves and disposed of them. -Left the resident's room and went to the kitchen area, passing three resident rooms with her contaminated hands. -She washed her hands when she got in the kitchen area.</p> <p>Observation of resident 1's room revealed there was a handwashing sink right next to his room.</p> <p>interview on 8/12/14 at 10:00 a.m. with licensed</p>	F 441	<p>F 441 contd: committee for as long as the committee deems necessary. Nursing in-service included appropriate dressing change technique for resident 10, appropriate disinfection of glucometers including for residents 10 and 17, appropriate glove use during insulin administration including for residents 10 and 17, appropriate hand hygiene and disinfection of equipment following care including for residents 1 and 10, and appropriate documentation of cleaning of resident's room per physician orders including for resident 1.</p> <p>Neighborhood Leader B provided personal in-service with return demonstration on 9-25-14 to Nurse F to ensure understanding and compliance with the process to clean the glucometers. A minimum of three random observation audits by Neighborhood Leader B on Nurse F and other nurses will be completed on cleaning the blood glucometers will be completed a</p>	

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005	
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F 441	<p>Continued From page 30 practical nurse A revealed: *Staff should have used the closest sink to the resident's room to wash their hands. *Staff should not have gone into the kitchen area after providing care to a resident in isolation.</p> <p>6. Observation on 8/12/14 at 2:00 p.m. of resident 1 and CNA D revealed she: *Entered the resident's room, because his personal alarm was sounding. *Had put gloves on but had not put a gown on. *Was unable to find the device to shut the alarm off and asked the resident where he had put it. *Got down on her knees in front of the resident and placed her forearms on his knees and asked him where he had placed the device that was alarming.</p> <p>Interview on 8/12/14 at 4:00 p.m. with the neighborhood leader/RN C revealed: *Staff should have used the sink right outside resident 1's room to wash their hands. *Staff should have gowned any time they entered the room if they were going to have physical contact with the resident or his belongings while he was in isolation.</p> <p>7. Review of resident 1's physician's orders revealed an order that read "Clean Toileting areas and high touch areas in patients room daily with bleach containing cleaners."</p> <p>Review of resident 1's entire medical record revealed there was no documentation of daily cleaning of his room.</p> <p>Interview on 8/14/14 at 8:00 a.m. with an unidentified housekeeper revealed the caregivers were supposed to do the daily cleaning of</p>	F 441	F 441 contd: minimum of three times a week for three weeks beginning 9/26/2014. The Neighborhood Leader will conduct a minimum of three random observation audits per month thereafter with personal inservicing to be provided as necessary.	

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005		
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F 441	Continued From page 31 resident rooms Interview on 8/14/14 at 1:00 p.m. with RN D revealed they should have documented when they cleaned resident 1's room since it had been ordered by the physician. Review of the provider's November 2012 C-Diff policy revealed: *"Gloves should be worn to provide care to a resident who has diarrhea caused by C-Diff. *A gown should be worn to care for a resident who has diarrhea caused by C-diff if substantial contact with the resident or environmental surfaces is anticipated. *Gown and gloves should be removed before leaving the resident's room and hands must be washed immediately after completing care of the resident."	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2014
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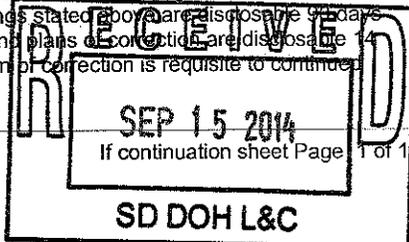
NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON	STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 8/12/14. Bethany Home - Brandon 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 New 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 <i>Jane Mullickson</i>	TITLE <i>Administrator, Emergency Permit Holder</i>	(X6) DATE <i>9/12/2014</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 disposable 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 disposable 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10677-2	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/14/2014
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NAME OF PROVIDER OR SUPPLIER BETHANY HOME BRANDON	STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005
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S 000	<p>Initial Comments</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/12/14 through 8/14/14. Bethany Home Brandon was found in compliance.</p>	S 000		

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

Gene Yulickson Administrator, Emergency Permit Hold

STATE FORM

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