

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

**ORIGINAL**

PRINTED: 08/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/14/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME SIOUX FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105</b>	
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F 000	INITIAL COMMENTS  Surveyor: 32355 A certification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/12/14 through 8/14/13, Bethany Home Sioux Falls was found not in compliance with the following requirements: F281, F329, F368, F441, and F514.	F 000		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure the policy and procedure for administering nebulizer treatments was followed by two of two observed nurses (C and D) for one of one sampled resident (1). Findings include:  1. Observation on 8/12/14 at 4:40 p.m. of registered nurse (RN) C preparing and administering a nebulizer treatment to resident 1 revealed: *She had gathered all of the necessary supplies to give the resident a nebulizer treatment. *She had entered the resident's room, retrieved the nebulizer mask and chamber and placed the medication inside of the chamber. *She placed the mask and chamber on the resident's face for administration and left the room.	F 281		

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

TITLE

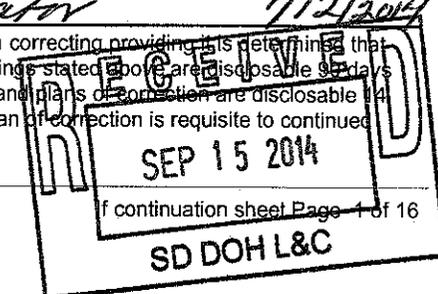
(X6) DATE

*Strom A. Schubert*

*Administrator*

*9/12/2014*

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



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F 281	<p>Continued From page 1</p> <p>*She returned to the resident's room at 5:20 p.m. to check on the resident.</p> <p>*The resident was not in the room, her nebulizer machine had been turned off, and the mask and chamber was laying on the bedside table.</p> <p>*That had been the only time in forty minutes she had checked on the resident.</p> <p>*She had not:</p> <ul style="list-style-type: none"> <li>-Encouraged the resident to cough several times during or after the administration of the nebulizer treatment.</li> <li>-Monitored the resident's pulse or respirations during the administration of the nebulizer treatment.</li> </ul> <p>Observation on 8/13/14 at 9:20 a.m. of RN D preparing and administering a nebulizer treatment to resident 1 revealed she had:</p> <ul style="list-style-type: none"> <li>*Set the resident up for a nebulizer treatment as mentioned above.</li> <li>*Returned to the resident's room at 9:30 a.m. to remove the mask and chamber from her face. She had checked on the resident three times during those ten minutes.</li> <li>*Not encouraged the resident to cough several times during or after the administration of the nebulizer treatment.</li> <li>*Not checked the resident's pulse or respirations during the administration of the nebulizer treatment.</li> </ul> <p>Review of the provider's September 2007 Aerosol Therapy Hand Held Nebulizer policy revealed:</p> <ul style="list-style-type: none"> <li>**"Have resident cough several times during and after treatment."</li> <li>**"Monitor pulse and respiration during treatment."</li> </ul> <p>Interview on 8/14/13 at 10:40 a.m. with the director of nursing revealed she would have</p>	F 281	<p>F281:</p> <ol style="list-style-type: none"> <li>1. The DON reviewed and revised the Aerosol Therapy Hand Held Nebulizer policy on 9-3-14. It was determined that the overall policy meets compliance and standards of practice with the following revisions being made: <ul style="list-style-type: none"> <li>-Add: pre- and post- neb assessment</li> <li>- Add: need to remain with resident</li> <li>-Add: documentation requirements</li> <li>-adjusted proper order of steps for infection control</li> </ul> </li> <li>2. The DON provided personal in-servicing with return demonstration to nurses C and D to ensure proper procedure for Nebulizer administration in accordance with the revised Aerosol Therapy Hand Held Nebulizer policy and procedure on 9-10-14.</li> <li>3. The DON provided education on proper revised procedure for Nebulizer administration in accordance with the policy to all licensed nursing staff on 9-10-14.</li> <li>4. Neighborhood Leader will perform random Nebulizer administration audits and provide personal in-servicing as needed a minimum of 3 times per week for three weeks starting 9-15-14; then, a minimum of one per week for one month; then, a minimum of 2 per month thereafter. Random Nebulizer treatment audits will be recorded and reports will be submitted by the Neighborhood Leader to the quarterly QA committee for as long as the committee deems necessary.</li> <li>5. The DON observed the day shift Charge nurse administer a Nebulizer treatment to Resident 1 on 9-11-14. The nurse demonstrated proper protocol including proper hand hygiene and glove use per the revised Aerosol Hand held Nebulizer Policy and Procedure.</li> </ol>	<p><i>Chittany</i> <i>9/15/2014</i></p>	

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F 281	Continued From page 2 expected the nurses to follow the policy for nebulizer administration as stated above.	F 281		
F 329 SS=D	<b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b>  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.  This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to have necessary documentation to explain the need for duplicate drug therapy for two of seven sampled residents	F 329	F329: 1. DON reviewed the Psychotropic medication Policy and procedure on 9-3-14 and found it to be correct. 2. Neighborhood leader A obtained the following documentation that was added to the chart from resident 7's physician on 8-21-14: A diagnosis of 296.59 Bipolar II Depression was given for the medications Risperdone 0.25mg po daily at HS and Seroquel 25mg po daily in AM. The physician states, "This combination has been used for the last few years with success, attempted changes have failed to meet target behaviors" as rationale for why Resident 7 is taking 2 antipsychotic medications. The care plan was updated on 8-21-14 by the MDS coordinator to acknowledge the specific target behaviors exhibited. The DON obtained the following documentation and added it to the chart from Resident 1's physician on 9-8-14: A diagnosis of 311 Depression was given for the medication, Sertraline HCl 100mg po daily. A diagnosis of 780.52 Insomnia was given for the medication, Trazadone HCl 75mg po daily at HS. The care plan was updated by the Neighborhood leader to include the insomnia diagnosis and specific target behaviors on 9-8-14. Resident 1 has an appointment scheduled with a Psychiatrist for 9-15-14.	9/30/2014

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F 329	<p>Continued From page 3 (1 and 7) on psychotropic medications (any medication capable of affecting the mind, emotions, and behavior). Findings include:</p> <p>1. Review of resident 1's August 2014 medication administration record (MARs) revealed: *There had been two medications used for depression. *The first antidepressant medication was sertraline HCl. -She was to have taken 100 milligrams (mg) one time daily. *The second antidepressant medication was Trazodone HCl. -She was to have taken 75 mg at bedtime. *There had been no reason listed on the MAR for either of the two medications.</p> <p>Review of resident 1's medical record revealed: *An admission date of 6/12/12. *A depressive disorder diagnosis. *An unspecified psychosis (a loss of contact with reality) diagnosis. *A 12/17/13 physician's note that stated those medications would be reviewed by a psychiatrist. *There had been no psychiatric note explaining the need for two antidepressants. *There had been no recommendations by the pharmacist to explain the duplicate drug therapy. *There had been no documentation of why she had been prescribed two antidepressant medications.</p> <p>Interview on 8/14/14 at 8:45 a.m. and at 12:15 p.m. with neighborhood leader A regarding resident 1 revealed: *She was unable to locate any documentation that explained the need for the duplicate drug therapy.</p>	F 329	<p>3. The DON collaborated with the Consult Pharmacist, Admissions coordinator, MDS coordinator, and Neighborhood leader on 9-4-14 and determined the following: -When a Resident is admitted with duplicate drug therapy the admissions nurse will acquire the diagnosis for each drug, and specific rationale for use which identifies target symptoms from the physician at the time of admission to BLH starting 9-15-14. -If a physician prescribes a new medication that results in a dual therapy regimen, the nurse receiving the order will be responsible for notifying the prescribing physician and obtaining specific rationale, starting on 9-15-14.</p> <p>4. The consultant pharmacist will conduct audits on every resident with dual therapy medications and advise physicians of regulation compliance on a monthly and as needed basis starting 9-30-14.</p> <p>5. The Medical Director, Consultant pharmacist, and Nurse Managers will address issues of physician non-compliance with providing necessary diagnosis and/or rationale for dual therapy medications and formulate an acquiescence letter to be sent to physicians ensuring regulation obedience at the monthly Quality of Life meetings beginning 9-30-14.</p> <p>6. The Consult pharmacist will provide the DON a duplicate copy file of pharmacy consults requesting specific rationale from the physicians of residents on dual drug therapy at the monthly Quality of Life meetings starting 9-30-14.</p>		

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F 329	<p>Continued From page 4</p> <p>*She stated the resident had last seen behavioral health on 7/3/13.</p> <p>*She was unable to locate any documentation from that visit.</p> <p>Surveyor: 32355</p> <p>2. Review of resident 7's complete medical record revealed:</p> <p>*An admission date of 11/24/11.</p> <p>*She had the diagnoses of vascular dementia (memory loss) with behavioral disturbances, anxiety (nervousness), and depression (sadness).</p> <p>*There had been two medications used for her vascular dementia with behavioral disturbances.</p> <p>*The first antipsychotic medication was Seroquel 25 mg daily at noon.</p> <p>*The second antipsychotic medication was Risperdal 0.25 mg once a day at bedtime.</p> <p>*A 7/29/14 pharmacy consultation note requesting the primary physician to validate the need for the two antipsychotic medications. There had been no physician documentation or signature to support the physician had seen the consultation report as of this survey.</p> <p>*On 8/4/14 was seen by primary physician for her sixty day update. There had been no concerns and no changes on his progress report. There had been no documentation to support the pharmacists request on 7/29/14.</p> <p>Review of the physician's progress notes from July 2013 through August 2014 revealed no reason listed for administering both of the antipsychotic medications for the past year.</p> <p>Interview on 8/13/14 at 4:30 p.m. with neighborhood leader A regarding resident 7 revealed:</p>	F 329	<p>7. The DON will audit the pharmacy consult requests sent to physicians to ensure compliance of providing specific rationale in the residents chart for dual drug therapy twice monthly starting 9-30-14.</p> <p>8. The DON will submit a report of the audits of physicians compliance with providing documentation in resident's charts of specific rationale for dual drug therapy to the quarterly QA committee for as long as the committee deems necessary.</p>		

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F 329	Continued From page 5 *She was unable to locate any documentation from the physician supporting the need for the duplicate drug therapy. *She would have expected the physician to document the necessity for the two medications.  Interview on 8/14/14 at 10:50 a.m. with the director of nursing confirmed the above interview with neighborhood leader A.  3. Review of the provider's 7/1/14 Psychotropic Medications Policy revealed: *The provider would make every effort to comply with state and federal regulations. *The primary care physician would have documented the rationale and diagnosis for use and identified the target symptoms.	F 329		
F 368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME  Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.  There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.  The facility must offer snacks at bedtime daily.  When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.	F 368		

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F 368	Continued From page 6  This REQUIREMENT is not met as evidenced by: Surveyor: 32355  Surveyor: 32335 Based on interview and policy review, the provider failed to offer all residents a bedtime snack. Findings include:  1. Interview on 8/12/14 at 2:00 p.m. with a group of residents revealed not all residents were offered a bedtime snack.  Interview on 8/12/14 at 3:30 p.m. with resident 4 revealed she was alert and oriented to person, place, and time. She had never been offered a snack at bedtime. There were times when she would have liked to have been offered a snack.  Interview on 8/13/14 at 9:40 a.m. with neighborhood leader A revealed: *The staff had not been offering a bedtime snack to all the residents. *They had a list of residents who had physician's orders for a bedtime snack or who had medical conditions requiring them to have a snack at bedtime. *They had offered all the residents a bedtime snack in the past, but that had stopped a while ago. She had not been aware of why they had stopped offering all the residents a snack at bedtime.  Interview on 8/13/14 at 1:30 p.m. with the dietary manager revealed they had not been offering a bedtime snack to all residents. They had a list of residents who had medical conditions that required them to have a snack before bedtime.	F 368	F368: 1. DON reviewed and revised the "Nourishments" policy and procedure on 9-3-2014 to include: - Add: Dietary will supply snacks to each neighborhood before 7 p.m. - Add: the need for CNA documentation in PCC that HS snacks were offered and accepted. 2. All nursing and dietary staff will be provided education regarding revised nourishment policy by the DON on 9-11-14. 3. Dietary will supply snack options for each neighborhood daily by 7 p.m. starting on 9-15-14. Nursing will offer each resident a snack between 7-9p.m. in addition to providing medically necessary nourishments at HS starting 9-15-14. 4. Nursing will document in PCC that each resident was offered a snack and whether the snack was accepted, starting 9-15-14. 5. Neighborhood leaders will audit PCC documentation of HS snack offered on 5 random residents a minimum of 3 times weekly for 3 weeks, then once weekly for 1 month, then once monthly starting 9-15-14. Audits of PCC documentation of HS snacks will be documented and reports submitted by Neighborhood leader to the quarterly QA committee for as long as the committee deems necessary.	9/15/2014

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F 368	Continued From page 7 They were the only residents that were offered bedtime snacks on a regular basis. Dietary staff supplied the halls with snacks, but nursing staff were responsible for offering the snacks.  Interview on 8/14/14 at 10:45 a.m. with the director of nursing confirmed the interview with neighborhood leader A. She would have expected all residents to be offered a snack at bedtime.	F 368		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	<p>Continued From page 8</p> <p>(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.</p> <p>(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: 32335 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained for: *One of one observed dressing change done by registered nurse (RN) D for one of one sampled resident (1) with a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue). *One of two resident's (1) observed nebulizer treatment. *One of one resident's (8) observed blood glucose testing. Findings include:</p> <p>1. Observation on 8/13/14 at 10:00 a.m. of RN D changing resident 1's dressing revealed she: *Took a bag of supplies out of the treatment cart. *Put gloves on prior to entering the resident's room. *Had not washed her hands before putting on</p>	F 441		

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F 441	<p>Continued From page 9</p> <p>those gloves.</p> <p>*Had not taken the supplies out of the bag prior to starting the dressing change.</p> <p>*Removed the resident's soiled dressing.</p> <p>*Reached into the bag of supplies with those same gloves.</p> <p>*Left the room touching the door knob upon exiting and re-entering the room.</p> <p>*Had not changed gloves or washed her hands upon re-entering the room.</p> <p>*Had brought in gauze for the dressing change.</p> <p>*Had not cleaned the wound.</p> <p>*Opened the bottle of Dakins solution.</p> <p>*Reached into the bag of supplies and retrieved the protective cream.</p> <p>*Rubbed the protective cream around the wound.</p> <p>*Completed the dressing change.</p> <p>*Opened up four drawers and touched the clothing in the drawers with those same gloves.</p> <p>*She had been looking for a sock or slipper to cover the resident's toes.</p> <p>*She had also moved a floor mat looking for the slipper.</p> <p>*Put on the slipper and pressure relieving boot.</p> <p>*Put the supplies back into the bag.</p> <p>*Took off the gloves and threw them in the garbage.</p> <p>*Tied up the garbage and exited the room.</p> <p>*Had not washed her hands upon exiting the resident's room.</p> <p>*Opened up the treatment cart and put the bag of supplies back into the drawer.</p> <p>Interview at that time with RN D revealed: *When asked about washing her hands before beginning the dressing change she stated "I guess I didn't." *She agreed she should have washed her hands between taking off the soiled dressing and</p>	F 441	<p>F441:</p> <ol style="list-style-type: none"> <li>DON reviewed and revised the "Policy and Procedure for Non-Sterile Dressing Change" on 9-3-14 ensuring the first step is to wash hands and to define "clean field". The revisions include: <ul style="list-style-type: none"> <li>- Obtain and set up equipment on a clean field by using a chux or a disposable leak proof drape.</li> <li>- Remove soiled dressings and discard according to facility policy.</li> </ul> </li> <li>The DON provided personal in-service with return demonstration on 9-10-14 to Nurse D to ensure understanding and compliance with the revised policy and procedure for non-sterile dressing change.</li> <li>The DON provided education on the revised non-sterile dressing change policy to all Nurses on 9-10-14.</li> <li>The Neighborhood Leader will complete random audits on non-sterile dressing changes a minimum of 3 times weekly for 3 weeks, then a minimum of once weekly for 1 month, then a minimum of once monthly starting 9-15-14. Non-sterile dressing change audits will be recorded and reports submitted by the Neighborhood Leader to the quarterly QA committee for as long as the committee deems necessary.</li> <li>On 9-11-14 the DON observed the day shift Charge nurse perform Resident 1's non-sterile dressing change per 9-3-14 revised policy. There were no concerns with procedure technique including hand hygiene and glove use.</li> </ol>	9/15/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/14/2014</b>
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F 441	<p>Continued From page 10 applying the clean one. *She stated she had not washed her hands in the resident's room before exiting, because she had to take out the garbage.</p> <p>Interview on 8/13/14 at 5:10 p.m. with the director of nursing (DON) revealed she would have expected RN D to have: *Washed her hands: -Upon entering the resident's room. -After handling the soiled dressing and before applying the clean dressing. -Before she had exited the resident's room. *Cleanse the wound before putting on the new dressing.</p> <p>Review of the provider's July 2013 Procedure for Handwashing policy revealed hands should be washed before touching clean items, after handling contaminated items, and after removing gloves.</p> <p>Review of the provider's January 2011 Non-Sterile Dressing Change policy revealed the procedure included: **Obtain and set up equipment on a clean field. *Wash hands thoroughly. *Provide for privacy and explain procedure to resident. *Apply non-sterile gloves. *Remove soiled dressings and discard in biohazard container per facility policy. *Observe wound characteristics - color, odor, drainage, size. *Remove soiled gloves and wash hands. *Apply clean pair of non-sterile gloves. *Cleanse wound according to physician order. *Dress wound according to physician order. *Secure dressings according to physician order.</p>	F 441			

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F 441	<p>Continued From page 11</p> <p>*Document procedure and would appearance in resident's chart."</p> <p>Surveyor: 32355</p> <p>2. Observation 8/12/14 at 4:40 p.m. of RN C revealed:</p> <p>*She had retrieved the necessary supplies to give resident 1 a nebulizer treatment.</p> <p>*She entered the resident's room, retrieved the nebulizer mask and chamber and placed the medication inside of the chamber for administration.</p> <p>*She placed the mask and chamber on the resident's face for administration and left the room.</p> <p>*When she had returned to check on the resident the mask and chamber had been removed, and had been laid on her bedside table.</p> <p>*She picked up the mask and chamber, turned on the water faucet, and them out.</p> <p>*She replaced the mask and chamber in a plastic container to dry.</p> <p>*She left the resident's room.</p> <p>*She had not washed her hands:</p> <ul style="list-style-type: none"> <li>-Prior to entering the resident's room or administering the medication.</li> <li>-Upon leaving the room after setting the resident up for the nebulizer treatment.</li> <li>-Prior to re-entering the resident's room to rinse out the mask and chamber.</li> <li>-Upon leaving the room after rinsing the mask and chamber.</li> </ul> <p>*She had not worn gloves:</p> <ul style="list-style-type: none"> <li>-While assisting the resident with the nebulizer treatment for administration.</li> <li>-When rinsing out the mask and chamber.</li> </ul> <p>Review of the provider's September 2007 Aerosol Therapy Hand Held Nebulizer policy revealed the</p>	F 441	<p>F441:</p> <p>Proper hand hygiene and glove use during Nebulizer treatments, non-sterile dressing changes, and glucometer disinfecting.</p> <p>6. The hand hygiene, policy was reviewed by DON on 9-3-14. Policy found to be correct.</p> <p>7. The DON provided personal in-servicing to Nurses B, C, and D on proper hand hygiene and glove use for infection control related to Nebulizer treatments, non-sterile dressing changes, and glucometer disinfecting with return demonstration 9-10-14.</p> <p>8. The DON provided nursing in-service education for all Nurses on the proper hand hygiene and glove use for infection control related to Nebulizer treatments, non-sterile dressing changes, and glucometer disinfecting on 9-10-14.</p> <p>9. The Neighborhood Leader will audit proper hand hygiene and glove use along with the non-sterile dressing change, nebulizer treatment administration, and glucometer disinfecting monitoring 3 times weekly for 3 weeks; then 1 time weekly for 1 month then once monthly thereafter beginning 9-15-14.</p> <p>10. Audits of proper hand hygiene and glove use for non-sterile dressing changes, nebulizer treatment administration, and glucometer disinfecting will be recorded and reports will be submitted by the Neighborhood leader to the quarterly QA committee for as long as the committee deems necessary.</p>	

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F 441	<p>Continued From page 12 staff were to have washed their hands prior to administering the nebulizer treatment and upon completion.</p> <p>Interview on 8/14/14 at 11:00 a.m. with the DON regarding the above observation confirmed there had been potential for cross-contamination of bacteria to other residents due to not following the policy for handwashing. She would have expected the staff to wear gloves while assisting the resident with the nebulizer treatment and rinsing of the apparatus.</p> <p>3. Observation on 8/12/14 at 4:45 p.m. of licensed practical nurse (B) revealed she had: *Retrieved the necessary supplies to check resident 8's blood sugar. *Entered the resident's room and laid the blood glucose meter (machine to test the levels of sugar in the blood) directly on his bedspread without a barrier (provides protection from bacteria to travel from one surface to another). *Checked the resident's blood sugar and left the room. *Placed the blood glucose meter in a plastic container of supplies to check blood sugar levels for all residents. *Not disinfected the blood glucose meter after testing the resident's blood sugar level and replacing it back inside the container.</p> <p>Observation on 8/12/14 at 5:00 p.m. of RN C revealed she had: *Retrieved the necessary supplies from the plastic container to check an unidentified resident's blood sugar level. *Retrieved the blood glucose meter along with the other supplies. *She had not observed LPN B placing the soiled</p>	F 441	<p>F441:</p> <p>11. Policy to clean and disinfect the blood glucose meter reviewed and revised on 9-3-14 by DON. Revisions include: - Add: Each diabetic resident has their own glucometer. - Add: The device is to be cleaned and disinfected between each glucose check. Then, wrap the EPA-approved wipe around the glucose test strip insertion site for at least four minutes. -Omit: Glucose meter is shared in a multi-resident setting...</p> <p>12. Personal Glucometers were ordered for each diabetic in the skilled nursing facility by the nursing secretary on 9-5-14.</p> <p>13. The DON provided Personal in-servicing with return demonstration on revised policy for disinfection of glucometers to Nurses B, C, and D on 9-10-14.</p> <p>14. The DON provided education on revised glucometer disinfection policy to all Nurses on 9-10-14.</p>	

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F 441	Continued From page 13 glucose meter back inside the container of supplies. *She had not disinfected the meter prior to entering the resident's room and testing her blood sugar.  Review of the provider's 2/7/12 Blood Glucose Meter Disinfecting policy revealed: **"Glucose meter is shared in a multi-resident use setting." **"The device is to be cleaned and disinfected with a Sani-Cloth bleach wipe between each resident use and let air dry."  Interview on 8/14/14 at 11:10 a.m. with the DON regarding the above observation revealed she would have expected the staff to disinfect the blood glucose meter as directed by the provider's policy. There had been potential for cross-contamination to all residents who required their blood sugar levels checked with the blood glucose meter.	F 441	15. Random glucometer disinfecting audits will be conducted, by the Neighborhood leader, a minimum of 3 times per week for 3 weeks; then once weekly for 1 month; then once monthly thereafter starting 9-15-14. 16. The Neighborhood leader will record glucometer disinfecting audits and submit reports to the quarterly QA committee for as long as they deem necessary. 17. On 9-11-14 the DON observed the day shift Charge nurse perform glucometer disinfecting on Resident 8 per 9-3-14 revised Glucometer cleaning and disinfecting policy with no concerns including proper hand hygiene and glove use.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514			

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F 514	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to ensure weekly wound measurements were documented in the resident's chart for one of one sampled resident (1) with a pressure ulcer (a sore caused by unrelieved pressure that resulted in damage to tissue). Findings include:</p> <p>1. Review of resident 1's medical record revealed: *She had acquired a pressure ulcer to her right heel on 7/13/13. *There was no documentation of weekly wound measurements.</p> <p>Interview on 8/14/14 at 8:45 a.m. with neighborhood leader A and Minimum Data Set (MDS) assessment nurse revealed: *They had been taking weekly wound measurements, but they were not a part of the resident's medical record. *They had not used the documentation for the skin assessment that was in the computer. *They had a paper skin assessment document they completed that listed any resident that had a pressure ulcer. *Those paper skin assessment documents were not a part of the medical record.</p> <p>Interview on 8/14/14 at 11:15 a.m. with the director of nursing confirmed they had not been putting the weekly skin assessments and wound measurements into the resident's medical record.</p>	F 514	<p>F514:</p> <ol style="list-style-type: none"> <li>The DON and MDS Assessment coordinator reviewed the Prevention and Treatment of Skin Ulcers policy and procedure on 9-3-14 and found it to be correct.</li> <li>The MDS coordinator will include in her weekly assessment documentation and measurements in each residents chart starting 9-8-14.</li> <li>On 9/8/14 the DON monitored the presence of the weekly skin assessment on Resident 1's chart and found that a skin assessment was documented on 8/8/14, 8/14/14, and 8/21/14 by the MDS coordinator/Wound care nurse.</li> <li>Beginning 9-15-14, the DON will audit charts of all residents with skin ulcers to verify that weekly skin assessments are present, one time per week for 3 weeks, then monthly thereafter.</li> <li>Audits of the weekly skin assessment's presence on the chart will be recorded and reports will be submitted by the DON to the quarterly QA committee as long as the committee deems necessary.</li> </ol>	9/15/2014	

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F 514	Continued From page 15 Review of the provider's 7/1/14 Prevention and Treatment of Skin Ulcers policy revealed there had been no mention of documenting the weekly wound measurements in the resident's chart.	F 514			

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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/12/14. Bethany Home Sioux Falls (Building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities  The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 9/11/14 telephone to facility administrator. JB/KDD/MLF		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to conduct quarterly fire drills each quarter for the three shifts during three of the four previous quarters for the twelve month period beginning July 2013. Findings include:	K 050			

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

*Almond Dupont*

*Administrator*

*9/12/2014*

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 also usable 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 also usable 90 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 2  
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K 050	Continued From page 1 1. Fire drill record review at 10:00 a.m. on 8/12/14 revealed no documentation indicating a fire drill was conducted for the first shift (7 a.m.-3 p.m.) during the third quarter 2013 (July through September), the third shift (11 p.m.-7 a.m.) during the fourth quarter 2013 (October through December), and the third shift (11 p.m.-7 a.m.). Interview with the maintenance director during the record review confirmed the missing fire drills were not completed. This deficiency would affect the fire safety of the entire facility.	K 050	* 1. The "Fire Drill" policy was reviewed by the Administrator and the Maintenance Director on 9/8/2014. The policy was revised to include: "Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift, ensuring that each shift completes a drill per quarter." 2. Beginning 9/15/2014, the Maintenance Director will be responsible for ensuring that the drills are completed per the Fire Drill policy. The Maintenance Director will maintain documentation of the completed drills. Beginning 9/15/2014, the Administrator will sign off on documentation further ensuring its completion. 3. The Maintenance Director will submit completed fire drill reports to the quarterly QA Committee to monitor compliance for as long as the Committee deems necessary.  * JB/SDDH/MF	* 9/15/14 JB/SDDH/MF

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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/12/14. Bethany Home Sioux Falls (Building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities  The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to conduct quarterly fire drills each quarter for the three shifts during three of the four previous quarters for the twelve month period beginning July 2013. Findings include:	K 050		

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

TITLE

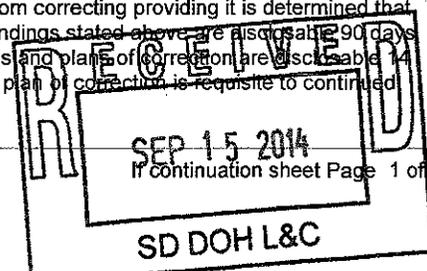
(X6) DATE

*Thomas Hubert*

*Administrator*

*9/12/2014*

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



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

PRINTED: 08/18/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - BUILDING 02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME SIOUX FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 1 1. Fire drill record review at 10:00 a.m. on 8/12/14 revealed no documentation indicating a fire drill was conducted for the first shift (7 a.m.-3 p.m.) during the third quarter 2013 (July through September), the third shift (11 p.m.-7 a.m.) during the fourth quarter 2013 (October through December), and the third shift (11 p.m.-7 a.m.). Interview with the maintenance director during the record review confirmed the missing fire drills were not completed. This deficiency would affect the fire safety of the entire facility.	K 050	1. The "Fire Drill" policy was reviewed by the Administrator and the Maintenance Director on 9/8/2014. The policy was revised to include: "Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift, ensuring that each shift completes a drill per quarter." 2. Beginning 9/15/2014, the Maintenance Director will be responsible for ensuring that the drills are completed per the Fire Drill policy. The Maintenance Director will maintain documentation of the completed drills. Beginning 9/15/2014, the Administrator will sign off on documentation further ensuring its completion. 3. The Maintenance Director will submit completed fire drill reports to the quarterly QA Committee to monitor compliance for as long as the Committee deems necessary.	9/15/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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ORIGINAL

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03</b> - BUILDING <b>03</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME SIOUX FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/12/14. Bethany Home Sioux Falls (Building 03) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities  The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies upon correction of the deficiency identified at K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	Addendums noted with an asterisk per 9/19/14 telephone to facility administrator. JBJ/DDO/HMF	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to conduct quarterly fire drills each quarter for the three shifts during three of the four previous quarters for the twelve month period beginning July 2013. Findings include:	K 050		

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

TITLE

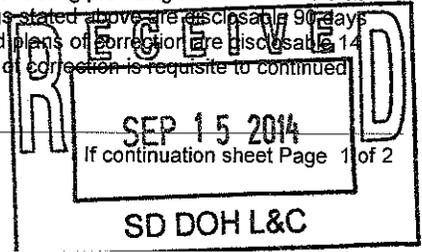
(X6) DATE

*Sumner Schubert*

*Administrator*

*9/12/2014*

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 excusable 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 excusable 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.



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435096</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - BUILDING 03</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/12/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME SIOUX FALLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 050	Continued From page 1 1. Fire drill record review at 10:00 a.m. on 8/12/14 revealed no documentation indicating a fire drill was conducted for the first shift (7 a.m.-3 p.m.) during the third quarter 2013 (July through September), the third shift (11 p.m.-7 a.m.) during the fourth quarter 2013 (October through December), and the third shift (11 p.m.-7 a.m.). Interview with the maintenance director during the record review confirmed the missing fire drills were not completed. This deficiency would affect the fire safety of the entire facility.	K 050	X 1. The "Fire Drill" policy was reviewed by the Administrator and the Maintenance Director on 9/8/2014. The policy was revised to include: "Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift, ensuring that each shift completes a drill per quarter." 2. Beginning 9/15/2014, the Maintenance Director will be responsible for ensuring that the drills are completed per the Fire Drill policy. The Maintenance Director will maintain documentation of the completed drills. Beginning 9/15/2014, the Administrator will sign off on documentation further ensuring its completion. 3. The Maintenance Director will submit completed fire drill reports to the quarterly QA Committee to monitor compliance for as long as the Committee deems necessary.  JB/SDDCH/MF	X 9/15/14 JB/SDDCH/MF	



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME SIOUX FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105</b>
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K 050	Continued From page 1 1. Fire drill record review at 10:00 a.m. on 8/12/14 revealed no documentation indicating a fire drill was conducted for the first shift (7 a.m.-3 p.m.) during the third quarter 2013 (July through September), the third shift (11 p.m.-7 a.m.) during the fourth quarter 2013 (October through December), and the third shift (11 p.m.-7 a.m.). Interview with the maintenance director during the record review confirmed the missing fire drills were not completed. This deficiency would affect the fire safety of the entire facility.	K 050	<p>1. The "Fire Drill" policy was reviewed by the Administrator and the Maintenance Director on 9/8/2014. The policy was revised to include: "Fire drills will be held at unexpected times under varying conditions, at least quarterly on each shift, ensuring that each shift completes a drill per quarter."</p> <p>2. Beginning 9/15/2014, the Maintenance Director will be responsible for ensuring that the drills are completed per the Fire Drill policy. The Maintenance Director will maintain documentation of the completed drills. Beginning 9/15/2014, the Administrator will sign off on documentation further ensuring its completion.</p> <p>3. The Maintenance Director will submit completed fire drill reports to the quarterly QA Committee to monitor compliance for as long as the Committee deems necessary.</p> <p style="text-align: right;">JD/SDDH/MF</p>	<p>*9/15/14 JD/SDDH/MF</p>
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**ORIGINAL**

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10677</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>08/14/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHANY HOME SIOUX FALLS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1901 S HOLLY AVENUE SIOUX FALLS, SD 57105</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p><b>Initial Comments</b></p> <p>Surveyor: 32355 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 Sioux Falls was found in compliance.</p>	S 000		

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

*Stephan Schubert*

STATE FORM

TITLE

*Administrative*

6899 S3DD11

