

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435073</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
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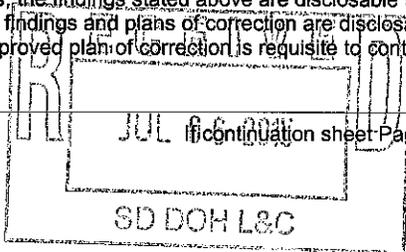
NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 28057 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/16/15 through 6/17/15. Bethesda Home of Aberdeen was found not in compliance with the following requirements: F222, F250, F281, F431, F441, and F514.</p>	F 000	<p>Addendums noted with an asterisk per 7/27/15 telephone to facility Administrator. KG/SD004/JJ</p>	
F 222 SS=D	<p><b>483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS</b></p> <p>The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (11) had not received a medication for the purpose of chemically restraining the resident. Findings include:</p> <p>1. Review of resident 11's physician's orders revealed: *He had an order for Zyprexa (antipsychotic medication for the treatment of mental illness) for: -One 5 milligram (mg) at 2:00 p.m., and 5 mg one-half tablet to be given at bedtime started on 4/16/15. -One 5 mg to be given twice a day PRN (as needed) for agitation started on 3/12/15.</p> <p>Review of resident 11's 6/7/15 care plan revealed:</p>	F 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Bence A. Johnson</i>	TITLE  <b>Administrator</b>	(X6) DATE  <b>July 2, 2015</b>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 222	<p>Continued From page 1</p> <p><b>**Problem: Dx [Diagnosis] of psychotic disorder with increased confusion-wandering exit seeking-verbally/physically abusive-disrobing. Dx of anxiety takes psych meds [medications].**</b></p> <p><b>*The goal was "Mood/behavior symptoms will be controlled with least amount of medications without adverse effects."</b></p> <p><b>*Approaches included:</b></p> <ul style="list-style-type: none"> <li>-Monitor mood/behavior symptoms.</li> <li>-Monitor for adverse effects of meds.</li> <li>-Give meds as ordered.</li> </ul> <p><b>*It had not addressed when they would re-evaluate its use or specific alternative attempts at managing behaviors.</b></p> <p>Review of resident 11's interdisciplinary notes revealed:</p> <p><b>*4/25/15-"This nurse administered a prn Zyprexa at 1609 (4:09 p.m.) in hopes of preventing aggressive sundowning behaviors, which he has had the past 3 nocs [nights] since returning from the hospital."</b></p> <p><b>*4/30/15-"PRN Zyprexa was given BID (twice a day) by the day shift nurse as prevention of behaviors after supper."</b></p> <p><b>*There was no documentation that any interventions were put in place to manage any potential behaviors before the medication was given.</b></p> <p>Interview on 6/17/15 at 2:30 p.m. with the director of nurses regarding resident 11 revealed:</p> <p><b>*He had in the past exhibited many behaviors including aggression toward other residents.</b></p> <p><b>*He had been hospitalized for his behaviors and was followed by a psychiatrist.</b></p> <p><b>*She agreed:</b></p> <ul style="list-style-type: none"> <li>-The physician order read to give the medication Zyprexa when the resident was agitated.</li> </ul>	F 222	<p><b>F 222 (1)</b> This deficiency has the potential to affect all residents.</p> <p>The Director of Nursing has determined there were no negative outcomes to Resident #11 regarding the administration of PRN medications.</p> <p>The policy and procedure for medication administration has been reviewed and rewritten.</p> <p>The Director of Nursing will educate all nurses at a nurse's meeting on July 21, 2015. Education will include administering PRN medication and the use of alternative attempts at managing behaviors. The Director of Nursing will also review the policy with the pharmacist at the Pharmacy meeting to be held July 14, 2015.</p> <p>The Quality Improvement Coordinator will audit the appropriate use of any PRN antipsychotic and antianxiety medications and other alternative attempts being utilized on a weekly basis for 8 weeks and then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report all findings to the Director of Nursing.</p> <p>The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	7-21-15

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F 222	Continued From page 2 -Agitation could have been interpreted differently by different staff. -The nurse should not have given the medication if the resident was not agitated or to prevent the behavior.  Review of the provider's 11/2/14 staff training information revealed: **Restrains: Physical, chemical or mechanical devices used to restrict the movement of a patient or resident or the movement or normal function of a portion of the patient's or resident's body, excluding devices used for specific medical and surgical treatment. *Interventions and effectiveness of less restrictive alternatives must be completed and documented prior to implementation of any type of restraint. *Restrains require a physician order including specific time frames and necessity of the restraint. The continued use of the restraint may be given only after a review of the client's condition by the physician and the interdisciplinary care team. *Examples of restraints: sedating medications."	F 222	* Resident 11 will not be included in the audits as the resident expired on 6/18/15.  Resident 11's physician and the medical director were sent a letter regarding the use of the PRN Zyprexa and in-services provided to the staff related to PRN medications.  KG/SDDH/JT		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE  The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, record review,	F 250			

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F 250	<p>Continued From page 3</p> <p>and job description review, the provider failed to ensure one of seven sampled residents (7) who had signs of depression received services. Findings include:</p> <p>1. Observation and interview of resident 7 on 6/16/15 at 10:45 a.m. revealed he: *Was alert and oriented. *Was tired a lot and spent most of his time sleeping. *Had attended more activities before, but now he only went to a couple of them. *Did not watch a lot of television in his room, but occasionally turned it on.</p> <p>Review of resident 7's following Minimum Data Set (MDS) assessments revealed: *On 11/17/14 he: -Scored a 9 on the mood assessment which was considered mild depression. -Indicated he felt down and bad about himself. -He had sleep issues, decreased energy, and difficulty concentrating. -Had a diagnosis of Depressive disorder and received a daily medication for depression. *On 2/10/15 he: -Scored a 7 on the mood assessment which was considered mild depression. -Indicated he felt down and bad about himself, and difficulty concentrating. -Had a diagnosis of Depressive disorder and received a medication for depression. *On 5/5/15 he: -Scored an 11 on the mood assessment which was considered moderate depression. -Indicated he felt down and bad about himself, had decreased energy, difficulty concentrating, and thought he would have been better off dead.</p>	F 250	<p>F 250 (1) This deficiency has the potential to affect all residents.</p> <p>The Licensed Social Worker and the Quality Care Team met on July 1, 2015 to review Resident #7 to ensure there were no further negative outcomes.</p> <p>On July 1, 2015 the Licensed Social Worker and Resident Care Coordinator visited with Resident #7 and his daughter/POA in regard to offering individual counseling or a referral to a Mental Health Counselor. Additional support through his spiritual home was offered.</p> <p>Social Service staff will audit all residents who have had mood scores in the moderate depression or higher category. Any resident with a mood score of moderate depression or above Social Services will visit with resident and/or family in regard to offering Mental Health Services. In addition Social Services will update the care plan to reflect needed approaches/interventions including other disciplines as necessary. Social Services will also visit with those residents twice monthly for at least a quarter or longer as deemed necessary based on the resident's mood/condition.</p> <p>Social Services will report weekly to the Quality Care Team on residents with moderate or above mood scores.</p> <p>Social Services will report monthly to the Quality Assurance and Performance Improvement Committee.</p> <p>The Quality Improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director.</p>	7-10-15

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F 250	<p>Continued From page 4</p> <p>Review of resident 7's physician's orders revealed on 5/19/15 the physician was notified of the resident's mood issues. The physician increased the dosage of his antidepressant Zoloft from 50 milligrams (mg) to 75 mg daily.</p> <p>Review of resident 7's 5/5/15 care plan revealed: *A problem of "History of negative thoughts concerning death and hurting self. Takes meds [medications] for depression." *Approaches included: -"Monitor mood for any neg [negative] comments regarding death." -Active listening. Support as needed. Give reassurance that staff was there to assist him. *It had not addressed: -Any specific interventions to address the depression such as referrals to outside agencies, individual counseling, spiritual support, or volunteer visiting. -Who specifically would monitor for mood changes. -Any changes in the care plan as his mood assessment changed from mild to moderate depression.</p> <p>Review of resident 7's entire medical record revealed: *The resident had not been offered individual counseling or a referral to a mental health counselor. *There was no evidence the staff offered any additional support in helping the resident to feel better about himself or his circumstances.</p> <p>Interview on 6/16/15 at 3:45 p.m. with registered nurse (RN) B regarding resident 7 revealed: *His mood varied from day to day, and throughout the day.</p>	F 250	<p>*An all staff in-service was held on 7/20/15 and 7/21/15 to educate staff. The in-service addressed identifying and reporting signs and symptoms of depression. KG/50004/JJ</p>		

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F 250	<p>Continued From page 5</p> <p>-He was grumpy at times, and refused to take his medications.</p> <p>Interview on 6/16/15 at 4:00 p.m. and review of the medical record with social worker A regarding resident 7 revealed:</p> <p>*She was aware he had indications of depression and had been sleeping more.</p> <p>*They had not made a referral for any counseling for him.</p> <p>*She confirmed the care plan addressed his depression, but it had not clearly defined what they would have done to address it.</p> <p>-It had not addressed who specifically would have been responsible for monitoring his mood and well being.</p> <p>*They had assisted the family in arranging a family event that involved an outing for the resident, and they had hoped that would help his mood.</p> <p>Interview on 6/16/15 at 5:00 p.m. with the registered nurse (RN)/resident care coordinator revealed she did not feel they had addressed his depression other than to increase the dose of the antidepressant.</p> <p>Review of the provider's March 2013 admission and social service coordinator job description revealed:</p> <p>**Essential Functions and Responsibilities included:</p> <p>-Identifies and evaluates personal, emotional and environmental concerns that might otherwise prevent or limit the resident's full use of medical, nursing and restorative care. Formulates a written plan of care for resident.</p> <p>-Gives assistance or help in locating and arranging for services of other professionals or</p>	F 250		

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F 250	Continued From page 6 agencies as needed. -Counsels new residents and their families to inform them of services to residents, utilizing resident's rights and responsibilities, and provides direct services to residents, utilizing available resources directed toward helping the resident solve problems associated with illness, disability and the aging process."	F 250		
F 281 SS=D	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: 26180  Surveyor: 35237 Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure one of one registered nurse (RN) (C) had not incorrectly delegated the inappropriate use of Eucerin cream to two of two certified nursing assistants (CNA's) (I and J) during one of one observed care for resident (8) . Findings include:  1. Observation and interview on 6/16/15 at 4:20 p.m. of resident 8's personal care with CNA I and J revealed: *She was lying in bed. *She had been incontinent (unable to control) of urine. *CNA J performed personal care with CNA I's assistance. *After CNA J had completed personal care she	F 281		

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F 281	<p>Continued From page 7</p> <p>grabbed a small plastic medication cup from the resident's bedside stand.</p> <p>-The cup had a white cream-like substance in it.</p> <p>*CNA J applied that cream to the resident's buttocks and private area.</p> <p>*CNA J stated she thought the cream was Eucerin (a brand name lotion/cream) and RN C had given it to them.</p> <p>-Both CNAs agreed the resident's buttocks were red, but they were not aware of any other skin issues.</p> <p>Interview on 6/16/15 at 4:40 p.m. with RN C revealed she:</p> <p>*Had given the Eucerin cream to CNA J and CNA I to use on resident 8.</p> <p>*Did not specify where they should have applied the cream.</p> <p>*Typically gave creams to the CNAs for them to apply.</p> <p>*Reviewed the resident's EMAR (electronic medication administration record) and stated the Eucerin cream had been ordered for the pressure areas (an area of injured skin from too much pressure) on her heels.</p> <p>*Agreed it should not have been applied to her buttocks.</p> <p>Review of the resident's medical record revealed:</p> <p>*She had pressure ulcers to both heels.</p> <p>*A 6/15/15 fax order from the physician for Eucerin cream twice a day to both heels until healed.</p> <p>Interview on 6/16/15 at 5:05 p.m. with the registered nurse (RN)/ resident care coordinator revealed:</p> <p>*If the Eucerin cream was ordered for a pressure ulcer then the nurse should have applied it.</p>	F 281	<p>F 281 (1) This deficiency has the potential to affect all residents.</p> <p>The Director of Nursing has determined there were no negative outcomes to Resident #8 regarding the administration of topical medications.</p> <p>The policy and procedure for administration of topical medications by a nurse has been reviewed and rewritten. All topical medications that have been ordered by a physician will be applied by the nurse or medication aide. Medication Aides can only administer topical medications if the area is not an open wound such as a pressure ulcer.</p> <p>The Director of Nursing will educate all nurses at a nurse's meeting on July 21, 2015.</p> <p>The Quality Improvement Coordinator will monitor one treatment on each neighborhood, weekly for 8 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report all findings to the Director of Nursing.</p> <p>The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	7-21-15

*to include resident 8's Eucerin cream, LG/spp/hjt*

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F 281	<p>Continued From page 8</p> <p>*She stated if it had been a prescription the nurse should be the one who applied it. *When asked if the nurses gave creams to the CNAs to apply she replied "unfortunately, yes."</p> <p>Interview on 6/17/15 at 8:30 a.m. with the director of nursing (DON) revealed: *The CNAs would apply some creams if they were not a prescribed medication. *If an order for a cream was new, medicated, or to an open area the nurse should have been the one to apply it. *She agreed there was a lack of communication from the nurse to the CNA related to the above observation. *She agreed the Eucerin cream was not applied as ordered.</p> <p>Review of the provider's undated Medication Topical Administration policy did not specify who was responsible for the administration.</p> <p>Further interview on 6/17/15 at 3:25 p.m. with the DON revealed the provider did not have a specific policy specifying what creams could have been applied by a CNA versus a nurse.</p> <p>Review of the provider's undated charge nurse job description revealed: *Duties included: -"Direct the day-to-day functions of the nursing assistants in accordance with current rules, regulations, and guidelines that govern the long-term care facility. -Ensure that all nursing service personnel are in compliance with their respective job descriptions." *Drug administration functions included: -"Prepare and administer medications as ordered by the physician."</p>	F 281			

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F 281	Continued From page 9 *Nursing care functions included: -"Ensure that direct nursing care be provided by a licensed nurse, a certified nursing assistant, and/or a nurse aide trainee qualified to perform the procedure." *Specific requirements included: -"Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long-term care. -"Must be able to relate information concerning a resident's condition."  Review of the provider's undated certified nursing assistant job description revealed no mention of administering creams ordered by the physician.  Review of Patricia A. Potter and Anne Griffin Perry et al, Fundamentals of Nursing, 8th Ed., St. Louis, Mo., 2013, p. 262 and p. 582, revealed: *"When a nurse delegates aspects of a patient's care to another staff member, the nurse who assigns the task is responsible for ensuring that each task is appropriately assigned and completed according to the standard of care." *"Administering medications to patients require knowledge and a set of skills that are unique to a nurse." *"Do not delegate any part of the medication administration process to nursing assistive personnel (NAP) and use the nursing process to integrate medication therapy into care."	F 281			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431			

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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 431	<p>Continued From page 10</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180</p> <p>Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to ensure: *Limited access to discarded Fentanyl patches</p>	F 431	<p>F 431 (1) This deficiency has the potential to affect all residents.</p> <p>The policy and procedure for Disposal of Medications including Narcotics has been reviewed and rewritten.</p> <p>The "Drug Buster" disposal system has been ordered and will be implemented on July 8, 2015 with education by the Staff education nurse.</p> <p>The policy and procedure for Disposal of Medications will be reviewed by the Director of Nurses at a nurse meeting on July 21, 2015. The Director of Nursing will also review the policy with the pharmacist at the Pharmacy meeting to be held July 14, 2015</p> <p>The Quality Improvement Coordinator will monitor the disposal of narcotics one time weekly for 8 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report all findings to the Director of Nursing.</p> <p>The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	7-21-15	

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F 431	<p>Continued From page 11</p> <p>(skin patch of narcotic pain medication) in one of one biohazard storage area.</p> <p>*An accurate count for resident 18's controlled medication for one of four observed controlled medication counts. Findings include:</p> <p>1. Interview and observation on 6/17/15 at 7:40 a.m. with licensed practical nurse (LPN) D regarding her process for discarding Fentanyl patches revealed:</p> <p>*She would have:</p> <ul style="list-style-type: none"> <li>-Removed a used skin patch from a resident.</li> <li>-Verified presence of the skin patch with another nurse.</li> <li>-Placed the patch in a sharps container (disposal for dirty needles and syringes) with another nurse present.</li> <li>-Placed the full sharps containers in the biohazard storage area in the boiler room.</li> </ul> <p>*The biohazard bins would have remained in the boiler room until they were picked up for destruction by an outside source.</p> <p>*An unlocked magnetic box with the key to the boiler room in it, on the door frame of the boiler room.</p> <p>*Several biohazard storage bins were inside the boiler room.</p> <p>Observation and interview on 6/17/15 at 8:30 a.m. of registered nurse (RN) C revealed she:</p> <ul style="list-style-type: none"> <li>*Removed a used Fentanyl skin patch from resident 17.</li> <li>*Verified presence of the skin patch with LPN D.</li> <li>*Disposed of the patch in the sharps container.</li> <li>*Stated she would have placed the sharps container in a red bin in the boiler room when it was full.</li> </ul> <p>Interview on 6/17/15 at 1:35 p.m. with the director</p>	F 431	<p>F 431 (2) This deficiency has the potential to affect all residents.</p> <p>The policy and procedure for Narcotic Administration and Control has been reviewed. The policy will be reviewed with all nurses and medication aides by the Director of Nursing at a meeting for all nurses and medication aides on July 21, 2015. Education will also include the proper procedure for deleting documentation.</p> <p>The Quality Improvement Coordinator will monitor the accuracy of narcotic counts <sup>to include resident 18's</sup> one time weekly for 8 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report all findings to the Director of Nursing.</p> <p>The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	7-21-15	

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F 431	<p>Continued From page 12 of nursing revealed she: *Would have expected the nurses to have placed: -Used Fentanyl patches in a sharps container. -Full sharps containers were stored in the red bins in the boiler room. *Agreed: -The key to the boiler room was in an unlocked magnetic box on the door frame of the boiler room. -Unauthorized personal would have been able to access the boiler room where the sharps containers were stored.</p> <p>Review of the provider's undated Medications Disposal Including Narcotics policy revealed "Used patches are placed in a sharps container with 2 nurses witnessing the disposal."</p> <p>Review of the provider's undated Disposal of Sharps policy revealed "When the container is 2/3 full. It is sealed and taken to the biohazard container in the boiler room."</p> <p>Review of the provider's undated Keys to Drug Storage and Narcotic Areas policy revealed "Access to drug storage areas are limited."</p> <p>2. Observation and interview on 6/16/15 at 5:45 p.m. with certified medication aide (CMA) E revealed: *Resident 18's narcotic record for Tramadol (a controlled pain medication) showed: -There were twenty pills remaining. -On line twenty, the writing had been scribbled out and could not be read. *There were nineteen pills in the medication card. *CMA E stated she had: -Performed the narcotic count when she came on duty with the night nurse going off duty.</p>	F 431		

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F 431	Continued From page 13 -Seen that line twenty of the narcotic record had been scribbled out. -Confirmed with the night nurse there were only nineteen pills in the medication card. -Confirmed with the night nurse the medication count and the number of pills in the medication card were not correct. -Been unable to find the missing pill. -Not reported the missing pill to anyone.  Interviews on 6/16/15 at 6:00 p.m. and at 6:25 p.m. with the director of nursing revealed: *CMA E and LPN F had not: -Reported the missing pill to her. -Completed the Missing Medication/Narcotic Form. -Followed their procedure for missing doses of a narcotic medication.  Interview on 6/16/15 at 6:30 p.m. with CMA E revealed she stated she: *Should have reported the discrepancy to the charge nurse. *Was not aware there was a form to fill out to report missing medications.  Review of the provider's 2/10/14 Narcotic Administration and Control policy regarding missing doses revealed staff were to: *"Inform the Charge Nurse/RCC [resident care coordinator] and/or Director of Nursing." *"Indicate the missing dose on the Narcotic Administration Record." *"Complete a Nursing Pharmacy Communication sheet indicating a dose is missing."	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 14</p> <p>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.</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:</p>	F 441	<p>F-441 (1) This deficiency has the potential to affect all residents.</p> <p>The policy and procedure for disinfecting the whirlpool tubs has been reviewed and rewritten. The disinfecting procedure has been placed in each tub room.</p> <p>The Director of Nursing and Staff Education Coordinator reviewed the policy and procedure with all bathing personnel on June 29, 2015* to include CNAs G and H. CNA bath aides will log cleaning times each time the tub is disinfected. The Quality Improvement Coordinator will monitor the logs weekly for 8 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Quality Improvement Coordinator will also observe the cleaning of a tub by each bath aide by July 21, 2015.</p> <p>The Quality Improvement Coordinator will report all findings to the Director of Nursing.</p> <p>The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	7-21-15	

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F 441	<p>Continued From page 15 Surveyor: 26180</p> <p>Surveyor: 35237 Based on observation, interview, manufacturer's instruction review, and procedure review, the provider failed to ensure proper disinfection of the whirlpool tub by two of two certified nursing assistants (CNA) (G and H) for two of three whirlpool tubs (A and E wings). Findings include:</p> <p>1. Interview on 6/17/15 at 10:02 a.m. with CNA G revealed he: *Had recently started giving baths. *Had been trained by another CNA on how to clean the whirlpool tub. *Cleaned the whirlpool tub after he gave the last resident a bath. *Explained his normal cleaning procedure of the whirlpool tub would have included: -Spray the surface of the tub with the disinfectant. -Fill the tub part way with the disinfectant and water and run the jets. -Scrub the surfaces of the tub and chair with a brush. -Drain the tub. -Rinse the disinfectant off with water. *Used Penner Patient Care Whirlpool Disinfectant Cleaner to clean the tub. *Had not been aware the treated surfaces needed to remain wet for ten minutes. *Normally rinsed the disinfectant off after scrubbing and would not leave it on for ten minutes. *Was unable to find instructions for cleaning the whirlpool tub in the tub room.</p> <p>Interview and observation on 6/17/15 at 10:10 a.m. with CNA H revealed she: *Had been giving baths for years in the facility.</p>	F 441			

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F 441	<p>Continued From page 16</p> <ul style="list-style-type: none"> <li>*Had watched a training video on how to clean the whirlpool tubs in the past.</li> <li>*Put the drain stopper in the tub.</li> <li>*Sprayed the interior surfaces of the tub and the chair with the hand sprayer that included disinfectant.</li> <li>*Pushed the button for disinfectant for a few seconds to add disinfectant to the tub along with a couple inches of water.</li> <li>*Ran the jets on the tub.</li> <li>*Stated she would have used a brush to scrub all the surfaces.</li> <li>*Stated she would let it sit for three to five minutes and then drain the tub.</li> <li>*After scrubbing she would have rinsed off the surfaces with water.</li> <li>*Used Penner Patient Care Whirlpool Disinfectant Cleaner to clean the tub.</li> <li>*Had not been aware the treated surfaces needed to remain wet for ten minutes.</li> <li>*Was unable to find instructions for cleaning the whirlpool tub in the tub room.</li> </ul> <p>Interview on 6/17/15 at 10:35 a.m. with the staff development/infection control nurse revealed she:</p> <ul style="list-style-type: none"> <li>*Expected the whirlpool tub to have been cleaned between every use.</li> <li>*Was not sure how long the disinfectant needed to remain on the surfaces.</li> <li>*Had not done any training with the bath aides.</li> <li>*Had not watched anyone clean the whirlpool tub.</li> <li>*Stated the bath aides watched a video on bathing and tub cleaning.</li> <li>*Agreed they should have instructions for cleaning the whirlpool tubs available in the tub room.</li> </ul> <p>Interview on 6/17/15 at 11:30 a.m. with the director of nursing revealed she expected the</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>manufacturer's instructions to be followed. She agreed if the instructions had not been followed the tub might not have been disinfected properly.</p> <p>Interview on 6/17/15 at 1:30 p.m. with the corporate compliance office/director of housekeeping and laundry revealed: *CNA H trained the other bath aides. *They also watched a video on how to clean the whirlpool tubs. *She had not watched anyone clean the tubs. *She agreed the disinfectant might not have been effective if not used for the ten minutes as directed by the manufacturer. *She agreed there could have been a risk to the residents if the tub had not been disinfected properly.</p> <p>Review of the provider's undated whirlpool bath E-wing procedure revealed: **"The pool disinfectant should be used to clean with." **"Brush corners of the tub, the bottom, back and sides of the chair. Allow this to set for 10 minutes."</p> <p>Review of the Penner Patient Care Whirlpool Disinfectant Cleaner label revealed directions that included the "treated surfaces must remain wet for 10 minutes."</p> <p>Review of the Cascade whirlpool tub daily maintenance instructions revealed: *To clean and disinfect the tub after every bath with Penner Cleaner/Disinfectant. **"Using the long-handled brush...thoroughly scrub all interior surfaces of the tub...Let the disinfectant stay on surfaces for 10 minutes. (Or, as recommended by the instructions on the</p>	F 441			

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F 441	Continued From page 18	F 441			
F 514 SS=D	disinfectant concentrate container)." 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.  This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure 1 of 14 sampled residents (7) had accurate medical records. Findings include:  1. Review of resident 7's physician's progress notes revealed: *He had been seen by his physician in November and December 2014, and January, February, March, and May 2015. *Each time the physician saw the resident his assessment indicated: -The resident had psychosis (mental illness). -The resident was unable to complete the review of systems due to patient confusion.	F 514			

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F 514	<p>Continued From page 19</p> <p>Review of resident 7's Minimum Data Set assessments revealed:</p> <p>*On 11/28/14: -A cognitive (memory) assessment had been completed, and he scored fifteen showing no memory or recall problems. -He had not had any acute (sudden onset) confusion or delirium (sudden onset confusion).</p> <p>*On 5/13/15: -He scored thirteen on his cognitive assessment indicating he had decreased concentration but no memory or recall problems. -He had not had any acute confusion or delirium.</p> <p>Review of resident 7's entire medical record revealed there was no evidence of any psychosis.</p> <p>Interview on 6/16/15 at 5:00 p.m. with the registered nurse/resident care coordinator regarding resident 7 revealed she was unsure why the physician documented the diagnosis of psychosis. That was not accurate.</p> <p>Interview on 6/17/15 at 10:00 a.m. with the director of nursing regarding resident 7 revealed: *He was alert and oriented. *She did not feel the assessment had been accurate regarding the confusion and psychosis.</p> <p>Review of the provider's undated medical record policy revealed it had not addressed the accuracy of the medical record.</p>	F 514	<p>F514 (1) This deficiency has the potential to affect all residents.</p> <p>The Director of Nursing has determined there were no negative outcomes to Resident #7 regarding the inaccurate medical documentation.</p> <p>On June 23, 2015, the Resident Care Coordinator visited with the physician for resident #7. The physician reviewed the resident's symptoms and removed the inaccurate documentation from the medical record.</p> <p>The Director of Nursing will review this deficiency at the nurses meeting to be held July 21, 2015.</p> <p>Nurses will monitor progress notes for accuracy when signing off on physician rounds. Any inaccuracies will be brought to the attention of the physician for his or her review/corrections.</p> <p>The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	7-21-15

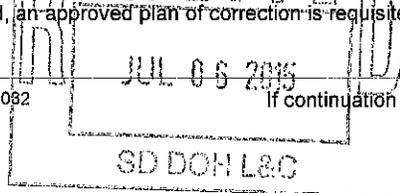
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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/16/15. Bethesda Home of Aberdeen (building 01-original structure) was found not 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 deficiencies identified at K029 and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of one of two hazardous areas (garage storage area attached to the 700 wing). Findings include:	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X6) DATE July 2, 2015

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: 06/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435073</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/16/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</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 029	Continued From page 1  1. Observation at 9:00 a.m. on 6/16/15 revealed the ninety minute fire-rated double-doors to the garages and storage room would not latch into the strike plates with the operation of the closer. The doors were out of shape in the lower half and the strikers appeared to be damaged. Interview with the maintenance supervisor at the time of the observation confirmed that finding.  The deficiency affected one of several requirements for providing separation of hazardous areas.	K 029	K 029 (1) This deficiency has the potential to affect all residents.  New knob and strike plates will be installed on the double doors to the garages by July 15, 2015.  Corporate Compliance Officer will audit all fire doors monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue.		
K 069 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to conduct the required annual inspection of the kitchen range exhaust ductwork. Findings include:  1. Document review on 6/16/15 at 2:45 p.m. of the kitchen hood system revealed there was no documentation indicating the exhaust ductwork had been thoroughly inspected for cleanliness/grease build-up. There was no documentation indicating the exhaust ductwork had been cleaned from the ventilator on the roof down to the range hood. Interview with the corporate compliance officer at the time of the document review revealed the inspection and subsequent cleaning had been overlooked since the previous maintenance supervisor ceased	K 069	The Maintenance Supervisor will report monthly to the Quality Assurance and Performance Improvement Committee.  The Quality Improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director.	7-15-15	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</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 069	Continued From page 2 employment for the provider.  The deficiency affected one of several requirements for protecting cooking facilities.	K 069	<p>K 069 (1) This deficiency has the potential to affect all residents.</p> <p>Aberdeen Hood and Duct, a local area contractor has been contracted with to inspect and clean the exhaust ductwork on the kitchen hood system. Cleaning will be done on July 14, 2015. The kitchen hood system will be checked twice yearly by Sigler Fire Equipment and will be cleaned when light grease or other indications warrant.</p> <p>The Maintenance supervisor will follow the cleaning and inspections and will report monthly to the Quality Assurance and Performance Improvement Committee.</p> <p>The Quality Improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director.</p>	7-14-15	

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

**ORIGINAL**

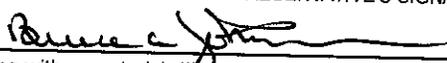
PRINTED: 06/29/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435073</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - <b>BUILDING 02</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/16/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</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) COMPLETION DATE
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/16/15. Bethesda Home of Aberdeen (Building 02 addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE <b>Administrator</b>	(X6) DATE <b>July 2, 2015</b>
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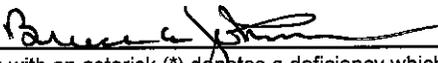
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435073</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>03 - ADULT DAYCARE</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/16/2015</b>
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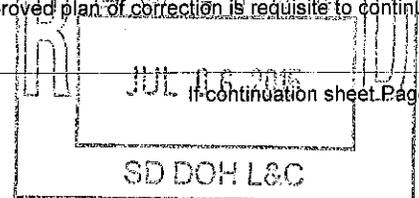
NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</b>
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K 000	INITIAL COMMENTS  Surveyor: 18087 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 6/16/15. Bethesda Home of Aberdeen (Building 03-therapy addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  	TITLE <b>Administrator</b>	(X6) DATE <b>July 2, 2015</b>
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10589</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</b>
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S 000	Initial Comments  Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted on 6/16/15 through 6/17/15. Bethesda Home of Aberdeen was found not in compliance with the following requirements: S156, S166, and S387.	S 000	<i>Addendums noted with an asterisk per 7/8/15 telephone to facility administrator. CH/SODOH/JS</i>	
S 156	44:04:02:12 VENTILATION  Electrically powered exhaust ventilation must be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in one randomly observed storage room (600 wing housekeeping closet). Findings include:  1. Observation at 9:45 a.m. on 6/16/15 in one randomly observed housekeeping storage closet in the 600 wing revealed the room's exhaust ventilation was not operating. Testing of the air flow at the grille with a paper towel by the maintenance supervisor at the time of the observation confirmed that finding. Interview with the maintenance supervisor at the time of the testing revealed a belt might have slipped on the exhaust fan motor.	S 156		

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

TITLE

(X6) DATE

*[Handwritten Signature]*

Administrator

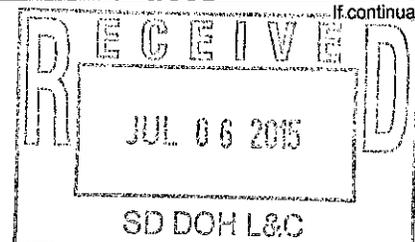
July 2, 2015

STATE FORM

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If continuation sheet 1 of 4



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10589</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/17/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</b>
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S 166	Continued From page 1	S 166		
S 166	<p>44:04:02:17(1-10) OCCUPANT PROTECTION</p> <p>The facility must take at least the following precautions:                      (1) Develop and implement a written and scheduled preventive maintenance program;                      (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents;                      (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit;                      (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities;                      (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks;                      (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed;                      (7) Portable space heaters and portable halogen lamps may not be used in a facility;                      (8) Household-type electric blankets or heating pads may not be used in a facility;                      (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof</p>	S 166	<p>S 156 (1) This deficiency has the potential to affect all residents.</p> <p>The exhaust ventilation in the 600 wing housekeeping closet will be repaired by July 31, 2015. Corporate Compliance Officer will monitor all housekeeping/janitor closets for properly working exhaust ventilation on a monthly basis until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>Corporate Compliance Officer will report monthly to the Quality Assurance and Performance Improvement Committee until the cleaning is completed.</p> <p>The Quality Improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director.</p>	7-31-15

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  10589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  06/17/2015
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NAME OF PROVIDER OR SUPPLIER  BETHESDA HOME OF ABERDEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401
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S 166	<p>Continued From page 2</p> <p>lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087</p> <p>A. Based on observation and interview, the provider failed to equip light fixtures in bathing rooms with lens covers or shatterproof bulbs for one of one randomly observed tub bathing room (G wing). Findings include:</p> <p>1. Observation at 9:30 a.m. on 6/16/15 of the tub room in the G wing revealed the heat lamp light fixture in the ceiling was not equipped with a lens cover or a shatterproof bulb. Interview with the maintenance supervisor at the time of the observation confirmed that finding.</p> <p>B. Based on observation and interview, the provider failed to install galvanized metal exhaust pipe for one of one dryer locations in the adult day care addition. Findings include:</p> <p>1. Observation at 9:45 a.m. on 6/16/15 of the dryer location in the adult day care addition revealed the two residential style dryers were equipped with foil type exhaust venting. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He stated he was aware the foil type exhaust was not allowed, but another staff person had installed the venting.</p>	S 166	<p>S 166 A &amp; B This deficiency has the potential to affect all residents.</p> <p>S 166 (A) A new shatterproof heat lamp bulb was replaced in the g wing tub room on June 18, 2015. An audit has been completed to ensure only shatterproof bulbs are used in any fixture over a resident bed, bathing area, supply storage rooms, clean laundry storage area or medication set-up areas.</p> <p>A meeting will be held on July 9, 2015 with the maintenance staff m nto educate on the proper use of shatterproof bulbs in designated areas.</p> <p>The Maintenance Supervisor will report monthly to the Quality Assurance and Performance Improvement Committee until the committee decides to discontinue. The Quality Improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director.</p> <p>S 166 (B) Lang's Appliance, a local appliance store will install galvanized metal exhaust pipe to the dryers in the Adult Day Health building on July 2, 2015. The Maintenance supervisor will follow the installation and will report to the Quality Assurance and Performance Improvement Committee at the next meeting.</p> <p>The Quality Improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director.</p>	7-9-15  CH/SOON/JJ

South Dakota Department of Health

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NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HOME OF ABERDEEN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1224 S HIGH ST ABERDEEN, SD 57401</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) COMPLETE DATE
S 387 S 387	Continued From page 3 44:04:13:26 Ventilating Systems  Vehicle parking garages must be provided with carbon monoxide detection to activate exhaust ventilation of six air changes each hour or to open the garage door if the area of the garage is under 1000 square feet. Signs must be posted at the front of parking spaces advising the driver to shut off the engine.  This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install carbon monoxide detection in the garages. Findings include:  1. Observation at 9:30 a.m. on 6/16/15 revealed the double garage where lawn equipment and snow moving equipment (with internal combustion engines) were housed was attached to the nursing home structure. Further observation revealed no carbon monoxide detection had been installed in the garage. Garages housing those types of motorized equipment must be equipped with carbon monoxide detection to activate exhaust ventilation of six air changes each hour. Interview with the maintenance supervisor at the time of the observation confirmed that finding.	S 387 S 387	S 387 (1) This deficiency has the potential to affect all residents. Signs have been posted in the garage advising drivers to shut off the vehicle engine. Schwan Electric, a local electrical contractor, will install a Carbon monoxide detector by August 6, 2015. The Maintenance supervisor will follow the installation and operation and will perform weekly test for 8 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. Corporate Compliance Officer will report monthly to the Quality Assurance and Performance Improvement Committee until work has been completed. The Quality improvement Coordinator will report to the quarterly Quality Assurance Committee with the Medical Director	8-6-15