South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11040	A. BUILDING: ____ B. WING ____	07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA TOWNE SQUARE	1425 15TH AVENUE SE ABERDEEN, SD 57401

(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	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 7/24/23 through 7/26/23. Bethesda Towne Square was found not in compliance with the following requirements: S105, S200, S201, S405, S685, and S701.	S 000		
S 105	44:70:02:06 Food service Food service shall be provided by a licensed facility or food service establishment that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, in the Food Service Code. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Food had been dated and identified when placed in one of one Beverage-Air refrigerator. *Outdated food was removed from potential staff providing for resident use in one of one Beverage-Air refrigerator. *There was no ice build-up on the refrigerator floor for one of one Piedmont Line refrigerator/freezer. Findings include: 1. Observation on 7/25/23 at 9:30 a.m. of the	S 105	All outdated and unlabeled food was removed and discarded on 7/25/2023. On 7/25/2023 all other refrigerators were checked to make sure there was no outdated or unlabeled food. On 7/26/2023, the Piedmont Line refrigerator/freezer had all food items removed and the temperature was adjusted down. On 7/27/2023 the refrigerator was turned off to help remove the ice until it could be cleaned. On 8/1/2023 it was determined a temperature control switch was needed.The refrigerator unit remains unused until the part is replaced. Education provided by Director of Culinary services on proper food storage and proper refrigerator cleaning and maintenance request for equipment will be provided to all culinary personnel on 8/16/2023. PRN staff or staff on leave will be educated prior to the start of their next shift. Audits for proper food storage and proper refrigerator cleaning will be conducted daily for two weeks, then weekly until QAPI determines sustained compliance. Audits will be conducted by the Director of Assisted Living or designee. Director of Assisted Living will report monthly to QAPI committee and quarterly to the QA&A committee with Medical Director.	9/9/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Scott Eisenbeisz	CEO/Administrator	8/15/2023

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S 105	Continued From page 1 Beverage-Air refrigerator revealed the following: *A plastic container labeled tomato soup dated 7/8. *A plastic container dated 7/14 that contained chicken noodle soup. *Three undated jelly rolls on a plate. *An undated full container of sliced oranges. *A tray of small plastic cups filled with a thick liquid: seven were red in color, five were orange in color, and three white in color. -One of the orange cups had a half-inch by half-inch piece of lettuce floating on top of the liquid. -There were no dates on the plastic wrap loosely covering all those containers. *An unlabeled, uncovered glass containing a chocolate liquid. 2. Observation on 7/25/23 at 9:40 a.m. of the Piedmont Line refrigerator/freezer combination revealed a quarter-inch layer of ice on the bottom of the refrigerator section. In the back was a four-inch high mound of solid ice. The refrigerator contained food items. The temperature was 41 degrees Fahrenheit. 3. Interview and record review with dietary aide D at the above times confirmed all of the above observations. Continued interview regarding the Piedmont Line refrigerator ice-build up revealed: *The ice had been there for a long time, approximately a year. *She was unaware if the problem had been reported to the maintenance department. *The ice build-up was cleaned every other day. *Cleaning of the refrigerator was to be documented on a weekly cleaning schedule. -Review of the July weekly cleaning schedule for the Piedmont Line refrigerator revealed no documentation for weeks one through four to	S 105		

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S 105	Continued From page 2	S 105		

support the cleaning had been done.

4. Interview and record review on 7/25/23 at 11:05 a.m. with culinary manager G revealed:
*She had a June 2023 monthly cleaning schedule for the Piedmont Line refrigerator that had been initialed by a staff member indicating the refrigerator had been cleaned.
-Review of the June 2023 monthly cleaning schedule form confirmed an employee's initials with no date when that cleaning had occurred.
*She had observed the layer of ice build-up on the bottom of the refrigerator, but had never seen the mound of ice build-up in the back of the refrigerator.
*The ice build-up had been occurring for a long time.
*The unlabeled tray of the small plastic cups, the chocolate drink, and the jelly rolls should have been labeled with date and contents.
*There was a small piece of lettuce in one of the salad dressings in the small plastic cups.
*The chicken noodle soup and the tomato soup "should have been discarded after five days as that was their policy."

Interview on 7/25/23 at 4:50 p.m. with assisted living (AL) maintenance manager C revealed he:
*Was not aware of the Piedmont Line refrigerator ice build-up.
*Had not received a maintenance request work order to have the area inspected and repaired if it required.
*Did not feel the ice build-up was a normal part of the refrigerator's function and it should have been looked at by a refrigerator repairman.

Interview on 7/25/23 at 4:55 p.m. with AL manager A revealed:
*She was not aware of the ice build up in the

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S 105	Continued From page 3 Piedmont Line refrigerator. *She had not entered the dietary department within the assisted living building to inspect the area. *The assisted living dietary department and the maintenance staff were managed by the nursing home staff. *She was not involved with either department as the dietary and maintenance staff were responsible for the kitchen area. Review of the provider's undated Food Storage policy revealed: *"Leftover food must be used within 7 days or discarded as per the 2017 Federal Food Code." *"All refrigerator units should be kept clean and in good working condition at all times." *"All foods should be covered, labeled, and dated and routinely monitored to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded."	S 105		
S 200	44:70:03:01 General fire safety Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition. An automatic sprinkler system is not required in existing facility unless significant renovations or remodeling occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling occurs. This Administrative Rule of South Dakota is not met as evidenced by:	S 200	Identified pantry door was fixed to allow for closure. Breakroom door was fixed and strike plate added to allow for closure. This was completed on 7/26/2023. Identified unsealed penetrations were repaired to create 2 hour fire resistance rating. The hallway was corrected with 2 pieces of 5/8 inch sheetrock on both sides of the penetration and then was sealed with fire caulk. The conduit was corrected with 2 pieces of 5/8 inch sheetrock and sealed with fire caulk. This was completed on 7/26/2023. No other areas were observed to have penetrations within the building. Maintenance staff was provided in-service training on the importance of maintaining smoke and fire barrier on 8/15/2023. Door audits for proper closing will be completed weekly for four weeks, then monthly for five months. This will be	9/9/2023

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S 200	Continued From page 4	S 200	added to monthly preventative maintenance program. Smoke/fire barrier penetration will be added to work project checklist for projects completed for both in-house and those completed by outside vendors. Maintenance supervisor will report any findings to Administrator. Administrator will take findings to monthly QAPI meeting and quarterly QA&A committee with Medical Director.	

A. Based on observation, testing, and interview, the provider failed to maintain two randomly observed one-hour fire-rated doors (pantry and employee lounge) as required. Findings include:

1. Observation on 7/25/23 at 1:15 p.m. revealed the garage/storage room was over 100 square feet in area and was considered a hazardous room. The adjacent kitchen had a pantry within the garage that was provided with a one-hour fire-rated door. Testing of the door revealed it would not close and latch with the operation of the closer.

2. Observation on 7/25/23 at 1:20 p.m. revealed the garage/storage room was over 100 square feet in area and was considered a hazardous room. The adjacent employee lounge was provided with a one-hour fire-rated door. Testing of the door revealed it would not close and latch with the operation of the closer. It was missing the strike plate in the door jamb.

B. Based on observation and interview, the provider failed to maintain the one-hour fire-rating of the garage enclosure at one randomly observed location (ceiling conduit penetrations). Findings include:

1. Observation on 7/25/23 at 1:25 p.m. revealed the garage/storage room was over 100 square feet in area and was considered a hazardous room. The ceiling had five two-inch diameter electrical conduits open at the ceiling. The openings were covered with duct tape which did not provide a one-hour fire-rating such as 5/8 gypsum board and fire-caulk.

Interview with the maintenance manager C at the time of the observations confirmed those findings.

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S 200	Continued From page 5 C. Based on observation and interview, the provider failed to maintain one randomly observed two-hour fire-rated wall (main core area to the 100 wing). Findings include: 1. Observation on 7/25/23 at 1:30 p.m. revealed the cross-corridor doors separating the main core area and the 100 wing were ninety-minute fire-rated doors in a two-hour fire-rated separation wall. Checking above the lay-in ceiling on the 100 wing side of the cross-corridor doors revealed unsealed penetration openings approximately twelve inches in diameter of the wall by metal pipe supports. Interview with the maintenance manager C at the time of the observations confirmed those findings.	S 200		
S 201	44:70:03:02 General fire safety Each facility must be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system must be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain egress emergency lighting in two randomly observed locations (southeast and northeast exits). Findings include: 1. Observation on 7/25/23 at 1:45 p.m. revealed the common egress corridor from the main floor	S 201	Proper battery operated illuminated exit signs were ordered on 7/25/2023 and arrived on 8/1/2023. Electrician will install illuminated exit lights by 8/21/23. Checking of the proper working of the illuminated exit lights will be added to monthly preventative maintenance program. Maintenance supervisory will report any findings to the Administrator. Administrator will take findings to monthly QAPI meeting and quarterly to the QA&A committee with Medical Director.	9/9/2023

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S 201	Continued From page 6 and the second-floor stair exit discharge was approximately thirty feet in length. The thirty feet of egress corridor path on the main floor to the southeast exit was not provided with emergency lighting. The northeast exit had a similar non-compliant configuration (no emergency lighting for the thirty feet of egress to the exit). Interview with the maintenance manager C at the time of the observations confirmed those findings.	S 201		
S 405	44:70:05:02 Resident care plans, service plans, and prog The nursing service of a facility shall provide safe and effective care from the day of admission through the ongoing development and implementation of written care plans or service plans for each resident. The care plan or service plan shall address personal care and the medical, physical, mental, and emotional needs of the resident. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure accurate evaluation documentation and an updated care plan for one of one sampled resident (3) who had a fall resulting in a nasal fracture. Findings include: 1. Review of resident 3's electronic care record documentation on 7/13/23 at 9:01 a.m. the resident had been seen at a local emergency room (ER) following a fall. The ER physician documented the resident had a nasal fracture and recommended ice to the area and to elevate the resident's bed.	S 405	Care plan was reviewed and revised for resident 3 to reflect current functional and cognitive needs. Care Plans will be reviewed and updated for any residents who have had a past fall in the last six months by licensed nursing staff. Care plan review and/or revised question will be added to the post fall huddle reviewd by Lead RN. Documentaion of post fall assessment by licensed nursing staff will occur per policy. Post fall questions will be asked and documented per policy by medication aides. Licensed nursing staff will review and revise care plan post fall per policy. Fall log and care plan will be reviewed prior to completion of Service Level of Care Evaluation by licensed nursing staff. Education was provided by the Administrator to Lead RN,Director of Assisted Living, and Licensed Nursing staff on roles and expectaions of documentation on 8/22/2023. Education will be provided by Lead RN and Director of Assisted Living by 8/31/2023 for licensed staff on updating care plans,and filling out Service Level of Care Evaluation. Education will also be provided by Lead RN and Director of Assisted Living Director by 8/31/2023 on post fall documenation per policy for all licensed nursing staff and medication aides PRN staff or staff on leave will be educated prior to the start of their next shift. Review of care plan will be conducted post fall by	9/9/2023

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S 405	Continued From page 7 Review of resident 3's Senior Living Level of Care Evaluation completed nine days after the above fall on 7/22/23 by licensed practical nurse K revealed in section 18, question 5 "Does the resident have a known recent history of falling (3 months) and/or is the resident at high risk for falls?" The answer was "No." Review of resident 3's current care plan revealed: *A focus statement "The resident has had an actual fall" was revised on 4/22/23. -The column for interventions was last revised on 4/22/23. *A focus statement revised on 4/22/23 "The resident is at risk for falls r/t [related to] balance problems, confusion, gait problems, hx [history] of falls, non-compliance with mobility aide use, poor safety awareness." -The column for interventions was last revised on 4/22/23. -There was no documentation to support that the care plan had been reviewed or revised after the 7/13/23 fall with the nasal fracture and interventions related to the fall. Interview and record review on 7/25/23 at 3:20 p.m. of the 7/13/23 Post-Fall Huddle form with LPN E revealed: *A post-fall huddle form was completed at the time of the fall. That form indicated the following: -Information related to the time of the fall. -The post-fall checklist reminder included to document in the communication book and to complete a full set of neuros (neurological assessment) and to pass it on to the next shift if needed. -Was the care plan reviewed? Or revised? There was no documentation to support either had been reviewed or revised.	S 405	licensed nursing staff. Director or Assisted living or designee will audit all falls for compliance of care plans being updated within 24 hours. Director of Assisted Living will report to monthly QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 405	Continued From page 8 -Was the care plan followed as written? -With documentation that had indicated "yes." Review of the provider's 2/16/21 Fall/Accident Prevention and Management policy revealed: *The licensed nurse was to evaluate the plan of care as needed. *The section for post-fall management had not addressed updating or revising the resident's care plan following a fall. Interview on 7/25/23 at 5:30 p.m. with assisted living manager A revealed: *It was unknown why the Senior Living Level of Care Evaluation completed on 7/22/23 by LPN K was not accurate or why the care plan had not been updated after resident 3's fall. *Registered nurse H would indicate that she was not aware as a nurse to document on the resident's status. Refer to S701.	S 405		
S 685	44:70:07:09 Self-administration of drugs A resident with the cognitive ability to understand may self-administer medications. At least every three months, the licensed nurse, the physician, physician assistant, or nurse practitioner shall evaluate and record the continued appropriateness of the resident's ability to self-administer medications. The determination must state whether the resident or the nursing staff is responsible for storage of the drug and include documentation of its administration in accordance with the provisions of chapter 44:70:07. A resident may self-administer drugs if the registered nurse, if applicable, and physician, physician assistant, or	S 685	The expired eye drops from Reisdent 1 were removed on 7/25/2023. Review of potential other expired self-administered drugs was conducted. Resident 1 quarterly self-administration safety screen was completed by licensed nursing staff. Updated self-administered safety screen for all other residents will be completed by 8/31/2023 by licensed nursing staff. Policy updated to reflect that licensed nurses can update and do initial and quarterly self-administration safety screen. Inservice on self-administration drug policy and procedures for licensed nursing staff will be conducted by 8/31/2023 by lead RN and Director of Assisted living.PRN staff or staff on leave will be educated prior to the start of thier next shift.	9/9/2023

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S 685	Continued From page 9 nurse practitioner have determined the practice is safe. No resident may keep medications on the resident's person or in the resident's room without a medication order allowing self-administration. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure for one of one sampled resident (1) who self-administered medications to ensure: *The medications the resident self-administered had not been used beyond the manufacturer's expiration date. *A quarterly assessment had been completed by a licensed nurse to ensure the resident was capable to continue to self-administer medications. *The provider's policy had been implemented allowing resident's to self-administer medications. Findings include: 1. Observation and interview on 7/25/23 at 3:40 p.m. with resident 1 on a stand next to her chair in her room revealed the following eye drop bottles: *Eye Itch Relief eye drops, with a manufacturer's expiration date June 2023. The resident indicated used the eye drops daily. *Clear Eyes eye drops with a manufacturer's expiration date of April 2023. The resident indicated she put those drops in at night. *She could not remember a nurse ever visiting with her about self-administering the eye drops. Review of resident 1's electronic care record and paper care record identified an initial medication self-administration form that had been completed	S 685	All residents who self-administer medication will have a self-administer medication log to include drug name, dosage, and expiration date. Director of Assisted Living or designee will audit logs weekly for one quarter, then everyother week for one quarter, then monthly thereafter. Quarterly safety screen audits will be conducted by Director of Assisted Living or designee weekly for one quarter than monthly thereafter. Director of Assisted Living will report monthly to QAPI committee and quarterly to the QA&A committee with Medical Director.	

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S 685	Continued From page 10	S 685		

on 12/15/22 following her admission to the facility. No further self-administration assessment documentation was found in those care records.

Review of resident 1's 1/4/23 physician orders revealed the following eye drops could have been self-administered:
*Refresh Relieve PF solution two drops in both eyes as needed.
*Clear Eyes two drops in both eyes as needed.

Review of resident 1's 7/22/23 Senior Living Level of Care Evaluation completed by licensed practical nurse (LPN) K, under section 5. Medication and Treatments, question 1, "Does the resident manage his/her own medications?" The response written was "no."

Review of resident 1's 7/26/23 care plan revealed it had not addressed the resident may self-administer the above eye drops.

Interview on 7/25/23 at 3:20 p.m. with LPN E revealed she was not aware:
*Of any self-administration assessments or evaluations conducted on residents who had self-administered medications or who should have completed the assessments or evaluations.
*Documentation should have occurred regarding the resident's ability to self-administer medications.
*She was not aware the eye drop medications had been used beyond the manufacturer's expiration date.

Interview 7/26/23 at 7:45 a.m. with registered nurse (RN) H revealed:
*She handled all new admissions for the independent living center, the assisted living center, and for the long-term care nursing home.

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*Conducting resident assessments of any kind was not in her job description and she did not conduct any assessments.
*She had no responsibility for the assisted living as their licensed nurse.
*She answered questions when asked by the assisted living staff, but did not do more than that in the facility.

Review of the Long Term Care Navigator Job Description signed 6/20/22 by RN H's the job summary revealed:
*The primary purpose of the Long-Term Care Navigator position was to function as an admissions liaison and to market services between all service lines of the organization, as well as to provide assessment potential of residents/clients, tenants for appropriate placement for services."
*"Position serves a nurse liaison for Bethesda Town Square, Parkside Retirement Community, and Bethesda Adult Services."
*"Position conducts employee prework screens for new hire employees of the organization."
*"The Long-Term Care Navigator is a key member of Bethesda's leadership team and collaborates directly with other key leaders to ensure the very best care in the organization."

Review of the provider's undated Self-Administration Policy revealed the nursing staff responsibilities included:
*"LPN nursing staff responsible for reviewing medication in apartment monthly."
*RN to evaluate continued appropriateness of the resident's ability to self-administer medication at least every three months."

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11040	A. BUILDING: ______ B. WING ______	07/26/2023

NAME OF PROVIDER OR SUPPLIER: **BETHESDA TOWNE SQUARE**

STREET ADDRESS, CITY, STATE, ZIP CODE: **1425 15TH AVENUE SE, ABERDEEN, SD 57401**

(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 701	Continued From page 12	S 701		
S 701	44:70:08:01 Record service The resident care records shall include the following: (1) Admission and discharge data including disposition of unused medications; (2) Report of the physician's, physician assistant's, or nurse practitioner 's admission physical evaluation for resident; (3) Physician, physician assistant, or nurse practitioner orders; (4) Medication entries; (5) Observations by personnel, resident's physician, physician assistant, nurse practitioner, or other persons authorized to care for the resident; and (6) Documentation that assures the individual needs of residents are identified and addressed. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, job description review, and policy review, the provider for one of one sampled resident (3) who had a fall that resulted in an emergency room visit with a physician assessment indicting a nasal fracture, the staff failed to: *Document the health status or condition by facility staff following the resident's return to the facility. *Document the implementation of physician ordered interventions. *Implement their policy to document resident care and condition following a fall. Findings include: 1. Review of resident 3's electronic care record documentation revealed on 7/13/23 at 3:48 a.m., licensed practical nurse (LPN) I from the	S 701	Unable to correct prior noncomplance for resident number 3. Documentation of post fall assessment by licensed nursing staff will occur per policy for all future falls. Post fall questions will be asked and documented per policy by medication aides. Licensed nursing staff will review and revise care plan post fall per policy. All staff will be educated on the Fall/Accident Prevention and Management policy and process for fall and post fall follow-up by Lead RN and Director of Assisted Living. This will occur by 8/31/2023. PRN staff or staff on leave will be educated prior to the start of their next shift. Education will be provided by Administrator to Lead RN and Licensed nursing staff on roles and expections of documentation on 8/22/2023. Director of Assisted Living or designee will audit review of post fall documentation and follow-up per policy for all falls. Director of Assisted Living will report monthly to QAPI committee and quarterly to the QA&A committee with Medical Director.	9/9/2023

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long-term care center documented "Staff from Towne square called nursing home nurse to notify of resident fall. She was found on the floor of her toilet, both eyes where [were] bruised, nose was swollen, back was bruised, she stated that she did not know what she was doing and she did not feel right. Nurse found that left eye 2mm [millimeters] reactive right eye 3 mm reactive. (City name) transfer service called."

Continued review of resident 3's electronic care record documentation revealed on 7/13/23 at 9:01 a.m. LPN J documented "(Resident name) returned by transfer service at 0805 from [hospital name ER (emergency room)]. DC [discharge] back to [provider name] Continue current orders. Nasal fracture found on CT (computed tomography). F/U [follow-up] w [with]/[physician name] or [physician name] if any concerns regarding healing. May help to ice 20 min [minutes] 3-4 X [times]/day and to sleep propped up X 1 week. [Physician name]"

Review of resident 3's 7/13/23 physician orders that were written on a progress notes from the ER revealed the same orders as written above.

Review of the resident 3's electronic care record and a paper care record regarding the resident's status after the fall had not addressed anything the following:
*Pain.
*Bruising or the healing status.
*Breathing or respiratory status.
*Any swelling or visual difficulties.
*The propping up of her bed while sleeping.
*Application of ice to the area for 20 minutes three to four times a day.
*Ability to walk.
*Assistance with activities of daily living such as

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S 701	Continued From page 14	S 701		

dressing or difficulty with eating.

Interview and review of the 7/13/23 Post-Fall Huddle form on 7/25/23 at 3:20 p.m. with LPN E revealed:
*There was no documentation completed by any staff member upon resident 3's return from the ER with a nasal fracture.
*The staff had been upset at the time as they had not been notified by the emergency room she was on her way back to the facility.
*A post fall huddle report was completed at the time of the fall.

Review of the post fall huddle report form indicated:
-Information related to the time of the fall.
-The post fall checklist reminder included to document in the communication book and to complete a full set of neuros and pass on to the next shift if needed.
-Was the care plan reviewed? Or revised? There was no documentation to indicate this had occurred.
--Review of resident 3's care plan revealed no documentation to support the care plan had been reviewed or revised after the fall.
-Was the care plan followed as written?
--The documentation indicated "yes."

Interview on 7/25/23 at 3:30 p.m. with assisted living manager A and LPN E revealed:
*There was no specific documentation policy on what the staff should document following a resident's injury.
*They had not documented the resident's care and condition or the resident's ongoing health status in the electronic care record or in the paper care record following her fall.
-They were not aware they should document the

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resident's status at any time.
*They had received any direction on what they should be doing for documentation in the resident's care records from anyone for the past year and a half.
*During the night there was no licensed staff in the assisted living and the unlicensed staff were not allowed to document in the resident's care records.

Interview 7/26/23 at 7:45 a.m. with registered nurse (RN) H revealed:
*She handled all new admissions for the independent living center, the assisted living center, and for the long-term care nursing home.
*She stated that was "news to me" when asked if she was considered the assisted living nurse who oversaw all resident care.
*Conducting resident assessments of any kind was not in her job description and she did not conduct any assessments.
*She answered questions when asked by the assisted living staff, but had not done more than that in the facility.
*There had been "no oversight by a RN for approximately one-and one-half years."

Interview on 7/26/23 at 9:10 a.m. with LPN F revealed:
*She had completed neurological assessments on residents who had fallen and hit their heads.
*During the night the medication aides were responsible to have the nursing home nurses conduct the neurological assessments. of residents.
*"If discharge orders do not say anything, then we don't do anything."
*If ice was ordered to have been applied it would have been done, but not documented.
-Was aware of the saying "if not documented, it

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was not done."

Interview on 7/26/23 during the exit interview with administrator B revealed:
*He had identified RN H as the facility nurse assigned for the assisted living on the Department of Health's Entrance Conference checklist.
*RN H was the assisted living facility nurse and he was not sure where the disconnect was about her position as the nurse for the assisted living.
*Resident care should have been documented to identify their care and condition.
*He stated if something was not documented, it was not done.

Review of the Long Term Care Navigator job description signed 6/20/22 for RN H's job summary revealed:
*The primary purpose of the Long-Term Care Navigator position is to function as an admission liaison and to market services between all service lines of organization, as well as to provide assessment potential of residents/clients, tenants for appropriate placement for services."
*"Position serves a nurse liaison for Bethesda Town Square, Parkside Retirement Community, and Bethesda Adult Services."
*"Position conducts employee prework screens for new hire employees of the organization."
*"The Long-Term Care Navigator is a key member of Bethesda's leadership team and collaborates directly with other key leaders to ensure the very best care in the organization."

Review of the provider's 2/16/21 Fall/Accident Prevention and Management policy indicated "Follow-up documentation is to be completed by both shifts for 72 hours following the incident. Place in calendar for 3 day/72 hours, as a F/U

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{S 000}	Compliance Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers was conducted on 9/14/23 and on 9/18/23 for deficiencies cited on 7/26/23. All deficiencies have been corrected, and no new noncompliance was found. Bethesda Towne Square is in compliance with all regulations surveyed.	{S 000}		

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