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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/18/23 through 7/20/23. Bethany Home Sioux Falls was found not in compliance with the following requirements: F640, F761, and F880.	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to	F 640		

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

Deborah Herrboldt | Administrator | 8/9/2023

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 640	Continued From page 1 the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interview and policy review the provider failed to ensure Minimum Data Set (MDS) discharge assessments were completed in a timely manner for two of two sampled residents (4 and 36). Findings include: 1. Review of the MDS transmission results summary report on 7/20/2023 provided by MDS coordinator C who was also the assistant director of nursing (ADON) revealed no discharge assessments had been submitted for residents 4 who had been discharged home on 1/28/23 and resident 36 who had been discharged home on 2/10/23. Review of the Resident Assessment Instrument (RAI) manual revealed discharge assessments when a resident's return was not anticipated were	F 640	On 7/24/2023, the ADON/MDS Coordinator C completed the discharge MDS assessments for residents 4 and 36. On 8/2/2023, the DON and Assistant Administrator, in consultation with the Medical Director, reviewed and revised the "MDS Completion and Submission Timeframes Policy" to define the DON as the backup to the ADON/MDS Coordinator C. On 8/2/2023, the DON and ADON/MDS Coordinator C reviewed and revised the "MDS Completion and Submission Timeframes Policy" to state "Bethany will utilize the dashboard alerts through the Point Click Care system and through the Interdisciplinary Team daily meeting to ensure timely completion of MDS assessments per the RAI manual.	9/3/2023

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F 640	Continued From page 2 to have been submitted no later than fourteen days after a resident discharged. Review of the providers 7/2017 MDS Completion and Submission Timeframes policy revealed: *"Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. -1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. -2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual." Interview on 7/20/23 at 5:45 p.m. with ADON/MDS coordinator C regarding discharge assessments for residents 4, and 36 revealed: *Completed MDS assessments were transmitted via the Internet Quality Improvement and Evaluation System. *She realized she missed completing the MDS assessment for resident 36 but thought she had completed the MDS assessment for resident 4. *She tracked the MDS assessments that would need to have been completed by utilizing the dashboard alerts in the PointClickCare system and through the morning huddle meeting. -The PointClickCare dashboard alerts were in place in the system for seven days then would fall off the list. -There was no report to print once the dashboard alerts were gone. *She had been gone when the MDS discharge assessments were due for residents 4 and 36.	F 640	On 8/4/2023, the Assistant Administrator provided personal in-service education with competency testing to the DON on the revised "MDS Completion and Submission Timeframes Policy" due to being assigned as the designee during this time frame. On 8/9/2023, the Assistant Administrator provided personal in-service education with competency testing to the ADON/MDS Coordinator C and nurse managers on the revised "MDS Completion and Submission Timeframes Policy." Beginning 8/10/2023, the ADON or her designee will audit all discharged resident MDS in the last year until all charts are audited completely. This will be completed by 9/3/2023. The ADON or her designee will present findings of the audits to the quarterly QAPI committee for as long as the committee necessary. Beginning 9/3/2023, the DON or her designee will audit 2 discharged resident MDS per week x 4 weeks and then monthly thereafter to ensure timely completion. The DON or her designee will present the findings of the audits to the quarterly QAPI committee for as long as the committee deems necessary.	

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F 640	Continued From page 3 *Director of nursing (DON) B was her back up to complete the MDS assessments when she was gone. *She believed the system in place to identify MDS assessments due for completion were effective. *She agreed the MDS discharge assessments for residents 4 and 36 were overdue and should have been completed.	F 640	On 8/9/2023, a nurse manager verified the order was correct and clarified the documentation for resident 27 to state utilization of bulk powder instead of packet.	9/3/2023
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced by:	F 761	On 7/20/2023, Registered Nurse Neighborhood Leader D verified the new dosage order was correct for resident 304. On 7/20/2023, LPN E placed the "Directions changed. Refer to chart" sticker on the corresponding medications for residents 27 and 304. On 7/20/2023, Registered Nurse Neighborhood Leader D ensured an adequate supply of stickers were available on all units. On 8/2/2023, the Assistant Administrator and DON, in consultation with the consulting pharmacist, reviewed the "Medication Administration Policy" and found it to be correct. On 8/2/2023, the Assistant Administrator and DON consulted with the consulting pharmacist regarding bulk medications. The Assistant Administrator, DON and consulting pharmasist agreed that bulk medications are the best practice. On 8/10/2023, the ADON/MDS Coordinator C provided a personal inservice education to LPN E on the "Medication Administration Policy" with competency testing.	

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F 761	Continued From page 4 Based on observation, interview, record review, and policy review, the provider failed to ensure medication prescription labels were accurate with the most recent physician's orders for two of twenty-eight medication labels reviewed. Findings include: 1. Observation and interview on 7/20/23 at 8:03 a.m. with licensed practical nurse (LPN) E during medication administration revealed: *She was preparing medications for resident 27. *She grabbed the resident's bottle of MiraLAX. -The prescription label had the following directions: "MiraLAX 17g [grams] in liquid by mouth every day as needed." *When she checked the physician's order for resident 27's MiraLAX, she found that there were two different orders for MiraLAX. -One order read, "MiraLax Oral Packet (Polyethylene Glycol 3350) Give 8.5 gram by mouth one time a day for constipation." --LPN E confirmed there were only bulk bottles of resident 27's powdered MiraLAX, and there were no oral packets as the physician's order called for. -The other order read, "MiraLax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350) Give 17 gram by mouth every 24 hours as needed for Constipation." *She confirmed the bottle of MiraLAX only had one prescription label on it. *She decided to wait on administering the resident's MiraLAX until she had a chance to contact the pharmacy. 2. Continued observation and interview on 7/20/23 at 8:25 a.m. with LPN E during medication administration revealed:	F 761	Beginning 8/7/2023, the DON or her designee will provide mandatory education to all nurses and medication aides on the "Medication Administration Policy" with competency testing. Beginning 8/7/2023, the DON or her designee will audit all medications to ensure accuracy of labels to orders matching and/or a sticker is placed with the label "Directions changed. Refer to chart" with completion date by 9/3/2023. The DON or her designee will present the findings of the audits to the quaterly QAPI committee for as long as the committee deems necessary. Beginning 9/3/2023, the DON or her designee will audit 4 resident medications for label accuracy and/or sticker placement, orders are correct, and new orders are communicated to pharmacy per week x 4 weeks and monthly thereafter. The DON or her designee will present the findings of the audits to the quarterly QAPI committee for as long as the committee deems necessary. Beginning 9/3/2023, the DON or her designee will audit all units weekly x4 weeks to ensure adequate sticker supplies are available. The DON or her designee will present their findings to the quarterly QAPI committee for as long as the committee deems necessary.	

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F 761	Continued From page 5 *She was preparing medications for resident 304. *She grabbed the resident's bottle of lactulose. -She explained that resident 304 usually refused the lactulose, but she would offer it to him anyway. *The prescription label on the bottle of lactulose read, "Lactulose 10g/15mL [milliliter] solution. Give 20g (30mL) by mouth three times per day." *She poured 15mL of lactulose into a liquid measuring cup. *When she checked the physician's order for resident 304's lactulose, she found that it was different than what the prescription label on the bottle had read. -The physician's order read, "Lactulose Oral Solution 10 GM/15M (Lactulose) Give 10 gram by mouth three times a day for liver disease." *LPN E decided to wait on administering the lactulose to resident 304 until she clarified the physician's order with the pharmacy. Interview on 7/20/23 at 9:05 a.m. with director of nursing (DON) B about medication prescription labels revealed: *Resident 304's label on the bottle of lactulose was from his admission. *The physician had since changed the order. *The current order was for 10g of lactulose, not 20g. *To change the prescription label on a resident's medication, they would have to call the pharmacy to request a new label with the correct dosing. -Until they received the new label, she expected a nurse to place a sticker that read "see new directions," or "see new orders" onto the prescription label. *She confirmed that: -Resident 304's lactulose order had changed on 7/15/23.	F 761		

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F 761	Continued From page 6 -A nurse should have put a sticker on the lactulose prescription label to prompt staff to verify the updated physician's order. -Staff should have continued to call the pharmacy to request a new label. -Resident 27 had two separate physician's orders for MiraLAX. --One order was for 17g as needed. --The other order was scheduled for 8.5g daily. -They used the same bottle for both orders. -There was only one prescription label on resident 27's bottle of MiraLAX. *She said, "Medication orders change all the time. It's hard to keep up with the bulk medication labeling." *When a resident's physician changed a medication order, nurses would send the new physician's order to the pharmacy. *They had to "hound" the pharmacy to get new labels, especially for the bulk medications in bottles. *The nurse working the floor was responsible for contacting the pharmacy to request new labels. Interview on 7/20/23 at 9:45 a.m. with registered nurse neighborhood leader D about resident medication prescription labels revealed: *She had called the pharmacy about requesting updated labels for resident 27's MiraLAX and resident 304's lactulose. *The pharmacist stated that they did not send new labels. -They indicated that it was acceptable for the facility nurses to place the above-mentioned stickers on the label. *The nursing staff should have put the stickers on the labels. -She confirmed there were no stickers available on the unit where LPN E was working.	F 761		

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F 761	Continued From page 7 -She retrieved the labels from a different unit and verified that each unit had the labels available. 3. Review of the provider's June 2023 "Medication Administration" policy revealed: *"7. The individual administering the medication much [must] check the label three times to verify the right resident, right medication, right dosage, right time, and right route of administration before giving the medication." *"8. If the dosage on a medication has been changed there must be a label placed on the container that states 'directions changed refer to chart.' The individual administering this medication should refer to chart for the correct dosage according to the most recent orders. Nurse should call pharmacy to get new medication container or label as needed."	F 761		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880	On 7/18/2023, IP D provided resident with hand hygiene education and assisted resident 304 with washing his hands. On 7/18/2023, LPN E cleaned and applied a bandaide to resident 304 arm. On 7/18/2023, IP D moved the narcotic binder to a seperate drawer on the medication cart away from the medications. On 7/18/2023, IP D moved all narcotic binders to a seperate drawer on the medication cart away from the medications on all units. On 7/18/2023, IP D reviewed all resident records and determined that no other residents were required to sign for medications prior to administration, eliminating the immediate need for hand hygiene education for all other residents prior to handling the pen and binder.	8/14/2023

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F 880	Continued From page 8 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880	On 7/20/2023, IP D provided personal inservice to LPN E regarding the "Bloodborne Pathogen Policy Exposure Control Plan" and "Standard Precautions Policy." On 8/1/2023, the Administrator, Assistant Administrator, DON B, and ADON collaborated with the Quality Improvement Advisor with the Great Plains QIN regarding a root cause analysis and identified the following Problem Statement and 5 Whys related to the deficiency: Problem: LPN E did not offer hand washing to resident 304 prior to resident touching the pen and binder. 5 Whys: 1. LPN E had not been educated on offering hand hygiene to the resident prior to touching the common supplies. 2. Having to sign for the medication was a unique situation for staff. 3. Education had been provided regarding necessity for signature, but hand hygiene prior to signing the book was an oversight. 4. LPN E had medications already dispensed in her hand. It was a confusing circumstance resulting in human error of timeline and prioritization. 5. LPN E did not call for assistance to help her through the situation. On 8/2/2023, the Administrator, Assistant Administrator, DON B, IP D, ADON, and Medical Director reviewed the "Bloodborne Pathogen Policy-Exposure Control Plan" and found it to be correct. On 8/2/2023, the Administrator, Assistant Administrator, DON B, IP D, ADON, and Medical Director reviewed and revised the "Standard Precautions Policy" to state "personnel assist the residents with washing hands with soap and water whenever blood or bodily fluids are present on resident hands." On 8/2/2023, the Administrator, Assistant Administrator, DON B, and IP D collaborated to create the "Blood and Bodily Fluids Exposure" policy. This policy provides detailed instructions to staff in the event they encounter residents with blood or body fluids on their hands. On 8/10/2023, LPN E was personally inserviced by the ADON on the revised "Standard Precautions" Policy and the new "Blood and Bodily Fluids Exposure" policy with competency testing.	

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F 880	Continued From page 9 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices were implemented for the following: *Ensuring one of one resident (304) had performed hand hygiene after he had touched his blood from a wound on his arm prior to having the resident sign his name in the narcotics binder. *Establishing a water management program that addressed the prevention of Legionella. Findings include: 1. Observation and interview on 7/20/23 at 8:42 a.m. with licensed practical nurse (LPN) E during medication administration revealed: *She had prepared medications for resident 304. *She donned clean gloves. *She grabbed the narcotics binder from the locked narcotics drawer in the medication cart. -There were several different types of narcotics that were prescribed for different residents. -The binder sat on top of the medications. *Upon entering the resident's room, the resident was found to have been bleeding from his right upper arm. -With his left hand, he pressed a piece of tissue paper to the small bleeding wound. -His left hand had blood on it. *LPN E said to the resident, "I will help you with	F 880	Beginning 8/7/2023, DON B or her designee will provide mandatory education to all nursing staff on the "Bloodborne Pathogen Policy-Exposure Control Plan," revised "Standard Precautions" policy, and the Blood and Bodily Fluids Exposure Policy" with competency testing. Beginning 9/3/2023, DON B or her designee will complete 10 random medication pass observation audits weekly to ensure proper hand hygiene is completed as indicated for both residents and nursing staff x4 weeks and then monthly therafter. DON B or her designee will report findings to the quarterly QAPI committee for as long as the committee deems necessary. On 8/1/2023, the Administrator, the Assistant Administrator, DON B, and the ADON collaborated with the Quality Improvement Advisor with the Great Plains QIN regarding a root cause analysis and identified the following Problem Statement and 5 Whys related to the deficideny. Problem: BHSF does not have a water management contractor to identify what the necessary guidelines are for an effective water management plan. 5 Whys: 1. Proposals sought but not accepted due to the need for a third proposal because of the high expense of the first two proposals. 2. The third request for proposal was never received due to the contractor not getting back to the Administrator. 3. Follow up hindered due to the circumstances and demands of the pandemic. 4. DON turnover and nursing workforce shortage challenges further distracted attention away from the pursuit of a water management contractor. 5. Attemps in 2023 to contact a local water management company failed due to the company not responding in a timely manner. On 8/2/2023, the Administrator, Assistant Administrator, DON B, IP D, and the Medical Director reviewed the "Legionella Surveillance and Detection" policy and found it to be correct and in line with the "CDC Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings" guidance. On 8/3/2023, a representative of a local water management company completed an onsite facility assessment to aid in the development of a detailed water management program specific to Bethany Home Sioux Falls.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105

(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 880	Continued From page 10 that after we take your meds." *One of the resident's medications was methadone. -The resident was required to sign his name in the narcotics binder after he had taken the methadone. *Without prompting or assisting the resident to perform hand hygiene, LPN E handed the narcotics binder to the resident. *Resident 304 grabbed the binder with his left hand, which had blood on it, and signed his name on the designated sheet. *After administering all of the resident's medications, LPN E brought the narcotics binder back to the medication cart. *When questioned about the interaction, LPN E had not realized that resident 304's hand had blood on it. *She proceeded to disinfect the binder before placing it back in the locked narcotics drawer in the medication cart. Interview on 7/20/23 at 9:12 a.m. with director of nursing (DON) B about the above observation revealed: *She expected staff to assist residents whom had noticeable blood on their body from a wound. *Staff were to use soap and water to cleanse the skin, not just hand sanitizer. *She confirmed: -It was her expectation for staff to address a bleeding wound prior to administering their medications. -The nurse should not have handed the narcotics binder to the resident due to the blood on his hand. Review of the provider's February 2021 "Bloodborne Pathogen Policy - Exposure Control	F 880	On 8/3/2023, a representative of a local water management company tested the level of sanitizer in the water by testing the chlorine levels in the water at Bethany Home Sioux Falls and found it to be within the acceptable range of 2.5-4.0ppm with a result of 3.4ppm. On 8/3/2023, a local plumber and local water management company respresentative began installing a bleach injection system into Bethany Home Sioux Falls water pipe system as a control measure. On 8/3/2023, the Administrator completed the CDC "Preventing Legionnaires' Disease (PreventLD Training) program. The Assistant Administrator, IP D, Maintenance Manager F, and DON B will complete the CDC "Preventing Legionnaires' Disease (PreventLD Training) program by 8/13/2023. On 8/7/2023, the Administrator, Maintenance Manager F, and a representative of a local water management company reviewed and revised the "Legionella Water Management Program" procedure per CDC guidance and SD DOH Administrative Rules to include specifics and details of measures, controls, and limits including a description of the system to monitor control limits; parameters for control limits; and created detailed water flow diagrams, diagrams of where control measures are located; diagrams of areas where legionella could grow and spread as part of an overall Water Management Plan to help prevent the spread of Legionella. The procedure was also revised to include a plan for when the control measures are not met and/or in the event of a positive Legionella test result. Additional revisions included adding more members to the Water Management Team, documentation requirements, and testing frequencies. The Water Management Team approved the revised "Legionella Water Management Program" procedure on 8/9/2023. On 8/9/2023, the Administrator, Maintenance Manager F, and IP D completed a Water Infection Control Risk Assessment (WICRA) for Healthcare settings. Beginning 8/7/2023, DON B, IP D, Administrator, and Maintenance Manager F will provide education to all employees on the Bethany Water Management Plan, the "Legionella Surveillance and Detection Policy" and the revised "Legionella Water Management Program" procedure with competency testing.	

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	435096	A. BUILDING _____ B. WING _____	07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105

(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 880	Continued From page 11 Plan" policy revealed there were no policy statements regarding when or how to help a resident with a bleeding wound. Review of the provider's June 2023 "Medication Administration" policy revealed: *"19. Staff shall follow established facility infection control procedures (e.g. [for example], handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable." 2. Interview on 7/20/23 at 3:48 p.m. with maintenance manager F about the provider's Legionella prevention plan revealed: *They were "just getting the water management plan up and running." *The topic of water management and Legionella came up at their quality assurance meeting in June. *He had not tested the level of sanitizer in the water. *He would pour water down the floor drains, but not on a scheduled basis. *When one of the units was closed for renovations, he would flush the toilets and turn the sinks on once a week to flush the pipes. *They were waiting on a contracted water management company to contact them about establishing their program. -He was not sure if there was a set date when the company would visit the facility. -His lact contact with the company was about three months ago. Interview on 7/20/23 at 4:45 p.m. with DON B and infection preventionist/neighborhood leader (IP) D about the provider's Legionella prevention plan revealed:	F 880	Beginning 8/14/2023, DON B or her designee will provide general orientation and annual mandatory education for all employees on the "Legionella Surveillance and Detection Policy." Beginning 8/14/2023, the Maintenance Director or his designee will provide general orientation and annual mandatory education for all employees on the "Legionella Water Management Program" procedure and the "Bethany Water Management Plan." Beginning 8/14/2023, the Water Management Team will meet monthly to review and plan regarding the effectiveness of the BHSF Water Management Program and to ensure compliance with the "Legionella Surveillance and Detection" policy and the revised "Legionella Water Management Program" procedure. Beginning 8/14/2023, the Administrator or her designee will complete a weekly audit of the Maintenenace Manager F documentation of visual checks, water temperature checks, and chlorine level checks to ensure that they are completed per the Bethany Legionella Water Management Program procedure. The Administrator or her designee will report findings on a monthly basis to the Water Management Team. The Administrator or her designee will also report findings to the quarterly QAPI committee for as long as the committee deems necessary. On 8/7/2023 an Infection Control ICAR risk assessment with all staff training was completed at BHSF.	

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	435096	A. BUILDING _____ B. WING _____	07/20/2023

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BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105

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F 880	Continued From page 12 *They went through the Legionella policy the previous month in their quality assurance meeting. *The members of the water management committee included the medical director, the administrator, the maintenance manager, the DON, and the IP. *They confirmed the following: -They had no established or defined measures, such as levels of disinfectants in the water or a target water temperature, used to control the introduction or spread of Legionella. -If a resident were to show signs or symptoms of pneumonia, then they would "check the measures in the water." -They were waiting on the water management company to contact them about setting up a water management program. Interview on 7/20/23 at 6:43 p.m. with administrator A about their water management program revealed they had been: *Aware that it was a requirement to establish a water management program that addressed Legionella control and prevention. *Attempting to contract with a water management company since they had no knowledge on how to manage a Legionella program. *Having difficulties with staying in contact with their chosen water management company. *Hindered by the pandemic to establish a plan. Review of the provider's communication e-mails with a local water management company revealed: *The local water management company reached out to the provider on 2/22/19. -They wanted to "follow up and see if you guys had made a decision on pursuing the water safety	F 880		

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F 880	Continued From page 13 plans or if you are still visiting on the subject?" *The provider responded on 2/25/19 stating, "We are still considering proposals. We will notify you as soon as we make our final decision." *A different water management company had provided them with an appraisal on 3/4/19. -The provider had not proceeded with that proposal. *The provider again reached out to the initial water management company on 6/16/23. -By the time of the survey, the provider was "waiting for them to follow up with the site visit." Review of the provider's September 2022 "Legionella Surveillance and Detection" policy revealed: *"3. As part of the infection prevention and control program, all cases of pneumonia that are diagnosed in residents [greater than] 48 hours after admission are investigated for possible Legionnaire's disease per CDC [Centers for Disease Control and Prevention] guidance." *"7. Residents who have signs and symptoms of pneumonia may be placed on transmission-based (droplet) precautions, although person-to-person transmission is rare." *"10. If Legionella is detected in one or more residents, the infection preventionist will:" -"a. initiate active surveillance for Legionnaire's diseases;" -"b. notify the water management team;" -"c. notify the local health department; and" -"d. notify the administrator and the director of nursing services." Review of the provider's September 2022 "Legionella Water Management Program" policy revealed: *"1. As part of the infection prevention and control	F 880		

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F 880	Continued From page 14 program, our facility has a water management program which is overseen by the water management team." *"3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease." *"5. The water management program includes the following elements:" -"e. Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants);" --The policy had not defined or established which measures were to be taken. -"f. The control limits or parameters that are acceptable and that are monitored;" --The policy had not defined acceptable parameters for the control limits. -"g. A diagram of where control measures are applied;" --There was a diagram of the water system in the facility, however, the diagram had not included where control measures were applied. -"h. A system to monitor control limits and the effectiveness of control measures;" --The policy had not included a description of a system to monitor control limits. -"i. A plan for when control limits are not met and/or control measures are not effective." --The policy had not defined a plan when control limits were not met.	F 880		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 7/18/23 through 7/20/23. Bethany Home Sioux Falls was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Herrboldt	Administrator	8/9/2023

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
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	435096	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/18/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	**1901 SOUTH HOLLY AVENUE** **SIOUX FALLS, SD 57105**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/18/23. Bethany Home Sioux Falls was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Deborah Herrboldt | Administrator | 8/9/2023

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

South Dakota Department of Health

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	10677	A. BUILDING: _____ B. WING _____	07/20/2023

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BETHANY HOME SIOUX FALLS	1901 S HOLLY AVENUE SIOUX FALLS, SD 57105

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/18/23 through 7/20/23. Bethany Home Sioux Falls was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Herrboldt

TITLE: Administrator

(X6) DATE: 8/9/2023