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
	435080	A. BUILDING ______ B. WING ______	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

(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 4/23/24 through 4/25/24. Bethesda of Beresford was found not in compliance with the following requirements: F575, F577, F578, F584, F585, F656, F688, F725, F761, F812, F851, F880, F909, and F919. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/23/24 through 4/25/24. Areas surveyed included environmental cleaning and sufficient staffing. Bethesda of Beresford was found not in compliance with the following requirements: F584 and F725.	F 000	The preparation of the following plan Of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 575 SS=D	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not	F 575	All residents have the potential to be affected by this deficient practice. The SD DOH contact information will be posted in a common location, viewable to all residents. Information including, but not limited to will include how to file a complaint. Resident admission packets will also be updated to include updated information regarding contact information on 5/10/24. The contact information for the local and State Ombudsman program will be posted in a common's area location, viewable to all residents on 5/10/24.	06/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 05/10/24

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.

[signature] Administrator 5/21/24

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F 575	Continued From page 1 limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and review of the resident admission packet, the provider failed to ensure the ombudsman and South Dakota Department of Health (SD DOH) contact information had been posted in a location accessible to all 35 current residents, visitors, and families. Findings include: 1. Interview with the resident council on 4/24/24 from 1:00 p.m. through 1:35 p.m. revealed the residents were: *Unaware where to find contact information for the ombudsman (resident advocate). *Not aware they could contact the SD DOH directly or file a complaint with the SD DOH. 2. Observation on 4/24/24 at 1:40 p.m. and again on 4/25/24 at 2:16 p.m. revealed the following: *The ombudsman contact information was posted in the entryway vestibule and the social worker's office. -In the entryway vestibule, the information was posted at standing-eye-level and required a door code to access the area. -In the social worker's office, there was a poster on the wall above the bookshelf. It was posted near the ceiling. The social worker's office was not always accessible to the residents. *There was no SD DOH contact information posted anywhere in the facility. *There was no statement posted that the resident	F 575	Administrator or designee will audit new admission paperwork to ensure SD DOH and ombudsman paperwork is included in each packet and ensure the required postings of each agency is posted in a conspicuous area weekly for 4 weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	

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F 575	Continued From page 2 could file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations. 3. Interview on 04/25/04 at 2:08 p.m. with administrator A confirmed: *The ombudsman's contact information was posted only in the social worker's office above a bookshelf. *The SD DOH contact information was not posted. *A statement that the resident could file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations was not posted. *A description of how to file a complaint with the state survey agency, SD DOH, was not posted. 4. Review of the admission handbook revealed: *The table of contents listed "State and Federal Contacts" was on page 19. *There was no page 19. *The "State and Federal Contacts" started on page 18. *The page after page 18 was labeled page 2. *Page 2 had contact information for the state ombudsman program, but it was not the current contact information. *The SD DOH complaint coordinator's phone number was not correct.	F 575		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and	F 577	All residents have the potential to be affected by this deficient practice. The survey results binder were posted next to the entrance of the business office and nurse's station on 5/10/24 for the 3 preceding years in a way readily accessible to all residents	06/09/2024

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F 577	Continued From page 3 (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and policy review, the provider failed to make the most recent survey results accessible to all residents and their representatives. Findings include: 1. Interview with the resident council on 4/24/24 from 1:00 p.m. through 1:35 p.m. revealed the residents were unaware of their right to read the state survey results or where to find them. Observation of the lobby and public areas on 4/24/24 at 1:40 p.m. and again on 4/25/24 at 2:16 p.m. revealed the survey results had not been made available. Interview on 04/25/04 at 2:08 p.m. with administrator A confirmed:	F 577	visitors and staff. Administrator or designee will audit the survey results are posted at the two locations and ensure they are readily accessible to anyone weekly for 4 weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	

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F 577	Continued From page 4 *The survey results were not currently posted. *The survey binder had been removed from the front lobby in January 2024 after a water leak. Review of the facility resident rights document in the admission packet provided to residents revealed the right to " ...examine the results of the most recent survey of [provider's name] conducted by Federal or State surveyors and any plan of correction in effect. Results are located at the nurses' station and next to the business office."	F 577		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578	Resident 32's medical record was updated to reflect the change of code status from "full code" to "DNR" on 4/24/24. All other residents' medical records were reviewed to ensure correct code status is displayed on the EMR. Administrator, DON, and interdisciplinary team review and revised, as necessary, the policy and procedure denoting code status on 5/10/24. ADM A and any other staff responsible for updating code status for residents will be re-educated.* Administrator or designee will audit correct code status on all residents weekly for 4 weeks and monthly for two months. *on the process and completion regarding code status updates by the DON. *BS 5/20/24	06/09/2024

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F 578	Continued From page 5 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to implement a revised advanced directive for one of sixteen sampled residents (32) reviewed for advance directives. Findings include: 1. Review of resident 32's paper and electronic medical record (EMR) revealed: *The dashboard indicated "full code." (Individual desire for cardiopulmonary resuscitation [CPR] to be initiated if their heart stopped.) *The physicians' order dated 11/21/23 indicated "full code." *The care conference notes dated 3/7/24 indicated "Code status was changed from Full Code to DNR [do not resuscitate]. Provider was faxed." Interview on 4/24/24 at 11:06 a.m. with administrator (ADM) A revealed: *It was her expectation that staff would look at the	F 578	Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	

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F 578	Continued From page 6	F 578		

EMR "dashboard" to find a resident's current code status.
*She recalled the power of attorney (POA) changed resident 32's code status at the last care conference that was held on 3/7/24.
*She stated, "I should have followed up with a new Expressions of Healthcare Preferences form."
*It was her expectation that when a resident code status changed:
-The Expression of Health Care Preferences form would have been completed with the resident or the resident's POA.
-That form would have been sent to the physician for signature and uploaded to the EMR.
-The physician orders and "dashboard" would have been updated.
*She confirmed that she "didn't follow up," and that the steps above had not been completed.

Interview on 4/25/24 at 11:02 a.m. with ADM A revealed she:
*Provided an Expression of Healthcare Preferences form for resident 32 dated 3/7/24.
*Provided a copy of a stamp that was typically stamped on the physicians' order.
*Indicated that the stamp provided the steps that should be followed after receiving all physician's order.
*Indicated they did not have an "Advance Directives Policy" as requested but provided a "Denoting Code Status" policy. .

Review of resident 32's Expression of Healthcare Preferences form revealed the form:
*Indicated, "I DO NOT desire cardiopulmonary resuscitation (CPR)."
*Was signed by the resident's POA on 3/7/24.
*Was signed by the physician on 3/8/24.

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F 578	Continued From page 7 *Had not been stamped with the stamp mentioned above. Review of the providers'12/01/2018 Denoting Code Status policy revealed: *"Upon admission, and after orders for advance directives have been received, an area by the resident's door is marked to denote their code status." *The policy did not mention: -The use of a stamp. -The steps or expectations indicated above by ADM A.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584	Activity room countertops have been decluttered of any supplies. Floors have been cleaned on 5/14/24. Scale room carpet was replaced on 5/14/24. The scale itself, hard plastic cover, will be repaired. 100-hallway hand sanitizer dispensers have been cleaned on 5/14/24. All other hand sanitizer dispensers have been cleaned on 5/14/24. Resident 22's wall will be patched and painted. The bathroom, including but not limited to, sink and shelving will be cleaned. The entry door will be repaired to remove any sharp edge. Resident 17's room had the cord replaced and taken off the floor on 5/14/24.	06/09/2024

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F 584	Continued From page 8 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure a clean and homelike environment was maintained in the following areas: *The activities room. *Resident rooms (1, 4, 5, 9, 13, 17, and 22). *The surfaces of the mechanical lifts. *The hand sanitizer dispensers. *The scale room. Findings include: 1. Observation on 4/23/24 at 8:13 a.m. in the activities room revealed: *There were glitter and confetti pieces on the tables and on the floor. *The counters were cluttered with several art and craft supplies that had not been put away (paper, puzzles, games, painting supplies, potting soil, crayons, colored pencils, markers). *There were dust bunnies, dead leaves, and dirt	F 584	Resident 9's entry door has been repaired to eliminate the sharp edge. Resident 5's room has been decluttered to include the extra side rail removed. Resident 1's room had her walker cleaned and new tennis balls installed. The room was deep cleaned. Resident 4's baseboard in entire room will be replaced. Walls to be patched and painted. Bedside table will be cleaned. Stand Aide #5 rubber safety caps will be replaced. Stand Aide #5 will be cleaned to remove any excess residue. Stand Aide #S1 will have the foot base cleaned and repaired to have a cleanable surface. 200-hallway tub room will have the tub chair replaced of missing, cracked, rusted or broken pieces. Top of storage shelf will be cleaned. Stand Aide 3 will have the platform cleaned. The rubber safety caps and protective covering on the wheel will be repaired. Stand Aide 4 will have the foot platform cleaned and free of debris.	

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F 584	Continued From page 9 particles on the floor throughout the room. 2. Observation on 4/23/24 at 8:36 a.m. in the scale room revealed: *The carpet had stained spots throughout the room. *There were bits of what appeared to be torn paper scattered on the floor. *The scale itself had flakes of an unidentified white material and was missing pieces of the plastic covering on the base. 3. Observation on 4/23/24 from 8:41 a.m. to 9:24 a.m. in the 100-hallway revealed: *The hand sanitizer drip tray outside of room 102 was dirty with dust and congealed hand sanitizer. *Resident 22's room had: -Scratches on the walls near the dresser. -A missing a chunk of wood with sharp edges on the bathroom door. -A shelf above the bathroom sink that was visibly dirty with an unidentified substance. *Resident 17's room, had a cord between the bed and the TV taped to the floor. The tape was peeling away, creating a potential tripping hazard. *Resident 9's room had sharp edges on the edge of the entry door. *Resident 5's room had a bed rail and several other items cluttered on the floor. 4. Observation and interview on 4/23/24 at 9:19 a.m. with resident 1 in her room revealed: *Her walker had a layer of dust buildup on the tennis balls on the feet of the walker. *She stated her room was "awful" and she wished her room was cleaner. 5. Observation on 4/23/24 from 9:35 a.m. to 9:56 a.m. throughout the facility revealed there were at	F 584	Resident 13's floor tiles will be replaced. The baseboard creating the gap will be replaced. Rm 208 hole in wall behind bed will be fixed. Rm 211 bed control cord will be fixed. All other resident rooms including, but not limited to will be inspected for cleanliness, baseboards to be repaired, walls patched, mechanical lifts and doors repaired. All other common use areas will be monitored for cleanliness. Administrator, DON, and interdisciplinary team reviewed and revised the maintenance work order and deep cleaning policy and procedure on 5/9/2024. Employee J and G will be re-educated by the Administrator or designee on work order policy and procedure. All other employees responsible for logging work orders will be re-educated. * Administrator or designee will audit cleanliness and repairs needed in resident rooms, lifts, and common use areas weekly for 4 weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	

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F 584	Continued From page 10 least 10 hand sanitizer drip trays that were soiled with congealed hand sanitizer and dust. 6. Observation and interview on 4/23/24 at 10:29 a.m. with resident 4 in his room revealed: *Long streak marks, chunks of paint, and exposed drywall areas missing along the bottom left edge of the wall. -At least three different areas where the drywall was exposed. -A two-foot missing section of the baseboard. -The remaining baseboard was peeling away from the walls. *He mentioned his wheelchair scrapes up against that side of the wall. *His bedside table was stained with a scattered clear glossy substance. It appeared to be sticky. 7. Observation on 4/23/24 at 10:52 a.m. of the "E-Z Way" stand aide labeled "#5" revealed the foot base was filthy with a buildup of an unidentified orange crust, the leg brace had specks of unidentified white flakes, and the rubber safety caps were missing from where the sling was hooked onto the machine. 8. Observation on 4/23/24 at 11:05 a.m. of the "E-Z Way" stand aide labeled "S1" revealed the foot base was filthy with dirt and food crumbs and was missing several areas of paint with rusty metal exposed. 9. Observation on 4/23/24 at 12:16 p.m. in the 200-hallway tub room revealed: *The tub chair had several areas that were cracked, broken, rusted, and missing plastic pieces. *The top of the storage shelf was unclean.	F 584	* Education will include what to look for when entering resident rooms or common areas, where and how to fill out a request for cleaning or repairing.	BS 5/20/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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F 584	Continued From page 11	F 584		

10. Observation on 4/23/24 at 2:52 p.m. of the "E-Z Way" stand aide labeled "3" revealed:
*There was a buildup of food particles and dirt in the foot base.
*The rubber safety caps were missing from where the sling was hooked onto the machine.
*One of the wheels was missing the protective covering.

11. Interview on 4/23/24 at 4:18 p.m. with resident 13's daughter revealed:
*She wished her mom's room was kept in a cleaner condition.
*When she visited, the floor in resident 13's room frequently had dust bunnies under and around the bed.
*The bedside table was often sticky with an unknown residue.
*The flooring tiles near the window were cracked.
*The common areas, such as the activities room, were "always messy and disorganized."
-Dirt and dust were commonly seen on the floor.

12. Observation on 4/24/24 at 8:34 a.m. in the activities room revealed it was in the same condition as stated previously.

13. Observations on 4/24/24 from 8:36 a.m. to 8:50 a.m. throughout the facility revealed that the hand sanitizer drip trays remained in the same condition.

14. Observation on 4/24/24 at 10:21 a.m. in resident 13's room revealed:
*Several floor tiles beneath her window were cracked.
-One of the tiles had a physical bump from the cracks.
-There was about a half-inch gap between the

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F 584	Continued From page 12 bottom of the baseboard and the floor tiles. 15. Observation on 4/24/24 from 10:43 a.m. to 10:53 a.m. throughout the facility revealed the mechanical lifts were in the same condition as stated previously. 16. Interview on 4/24/24 at 4:10 p.m. with business office manager J revealed: *He was a certified nurse aide (CNA) and helped fill in when needed. *If he saw something that needed fixing, he would write it in the maintenance request book located in the CNA room. *When he was in resident rooms, he normally looked for call light placement, not necessarily for environmental concerns that needed to have been fixed. 17. Interview on 4/25/24 at 9:28 a.m. with environmental services technician G about her normal cleaning routine revealed: *If she saw something that needed fixing, she verbally informed maintenance director D. *She had been the only housekeeper that week. *She was aware of the broken tiles in resident 13's room but had not informed maintenance director D. *She was aware of the state of resident 4's wall, but she explained that management knew about that. *She was not aware that the activity room was not clean. *A resident's room was deep cleaned when they changed rooms or if they were discharged. *There was no regular deep cleaning schedule if a resident had been living there for a long time. *The nursing staff were responsible for cleaning the resident mechanical lifts.	F 584		

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F 584	Continued From page 13 18. Observation on 4/25/24 at 9:42 a.m. of "E-Z Way" stand aide labeled "4" revealed there were food crumbs and pieces of cashew nuts in the foot base. 19. Interview on 4/25/24 at 10:19 a.m. with maintenance director D about building repairs revealed: *He checked the maintenance request book every morning. *He performed room checks once a month to see what needed to be repaired. *When asked if he kept a record of items that needed fixing or things that had been fixed already, he tapped his head and said he kept a mental note. *Larger repairs, like patching holes in walls and replacing the baseboard, was usually performed when the resident moved out or when the resident was not in the room. *He was aware of the needed repairs in resident 4's room. -He recently replaced a hole in that wall, explaining that was why part of the baseboard was missing. *He was constantly repairing scrapes in the walls from resident wheelchairs. *He was not aware of the broken tiles in resident 13's room. 20. Interview on 4/25/24 at 10:29 a.m. with CNA E about the mechanical lifts revealed: *Nursing staff were responsible for cleaning the mechanical lifts. *Bleach wipes were used to clean the high-touch areas in between each resident use. *She thought that the night staff were responsible for deep cleaning the mechanical lifts.	F 584		

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F 584	Continued From page 14 *She agreed there were cleanliness concerns with the mechanical lifts. 21. Review of the provider's Maintenance Requisition from 12/15/23 through 4/22/24 revealed: *There was a note from 2/20/24 that read, "Please have housekeeping check request log daily - does not look like things are being followed up on." *A request was submitted on 3/19/24 that read, "Rm. 208 hole in wall behind bed (headboard)." -The request had not been marked as "completed" by the time of the survey. *A request was submitted on 4/7/24 that read, "Room 211: bed control cord wires exposed." -The request had not been marked as "completed" by the time of the survey.	F 584		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.	F 585	This deficiency has the potential to impact all residents. Grievance forms were readily made available for all residents and representatives on 5/9/2024 at the front office and outside the social worker's door. Both forms are accessible from a wheelchair height. The grievance official is the social services designee. Notification of this change was indicated outside of the container to retrieve the forms on 5/9/24.	06/09/2024

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F 585	Continued From page 15 §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as	F 585	Notification of this change will also be re-introduced at the next resident council on 6/5/24 that the grievance official is the social services designee. Admin, DON, and interdisciplinary team reviewed and revised the Grievance Policy and Procedure on 5/14/24. Administrator or designee will audit availability and accessibility of grievance forms weekly for 4 weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	

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F 585	Continued From page 16 necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation, admission packet review, policy review, and plan of correction review, the provider failed to:	F 585		

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F 585	Continued From page 17 *Make information available on how to file a grievance and the location of the grievance forms readily available to residents and their representatives. *Designate who the grievance official was. Findings include: 1. Interview with the resident council on 4/24/24 from 1:00 p.m. through 1:35 p.m. revealed: *The residents were not aware of who the grievance official was. *The residents were not aware how to file a grievance or where to find the necessary forms. Observation of the lobby and the public area in the center of the facility around the nursing station on 4/24/24 at 1:40 p.m. and again on 4/25/24 at 2:16 p.m. revealed the grievance official contact information, how to file a grievance, and the grievance forms were not in prominent locations that would be readily available to anyone with a grievance. Interview on 04/25/04 at 2:08 p.m. with administrator A revealed: *She was the grievance official and "handles all the paperwork." *It was her expectation that residents "write it [the grievance] on regular paper" and that she would complete the grievance form. *Information on the grievance process was provided to residents at the November 2023 resident council meeting but she was unable to provide those resident council minutes. *Grievance information was kept in a black plastic pocket file hung on the wall above the nurses' station and noted the label on the file was missing. *The forms were kept where residents could not	F 585		

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F 585	Continued From page 18 reach them or prevent one of the residents from taking all of them. -She explained one of the residents had a habit of taking items from the nurses' station. Review of the provider's 10/24/23 admission packet revealed: *" ...there are also forms by the front office you can fill out with your concerns or thoughts." *The packet did not specify who the grievance official was. *There was no grievance form located in the packet. Review of the provider's Grievance policy effective 10/24/23 revealed: *"Upon request, the facility will provide residents or their representative(s) information regarding the internal grievance process including whom to contact to file a grievance." *The policy did not specify who the grievance official was. Review of the provider's plan of correction for the survey completed on 10/4/23 revealed: *"Resident Council will be held on 11/1/23 to discuss the new Grievance Policy and Procedure and where to locate them and announcing the Social Services Designee as the grievance official." *"Grievance forms will be located outside the nurse's station and included in the Resident Admission Handbook as well as ...next to the Administration office with clear signage and in plain view." *The provider was found in compliance with the plan of correction at the time of the revisit that was conducted on 11/7/23.	F 585		

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F 656	Continued From page 19	F 656		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656	Unable to timely correct resident 3's and 5's care plan. Physician orders were obtained for PT and OT to evaluate and treat residents 3 and 5 for development of restorative programs and individualized restorative goals. All other residents will be reviewed for the need for a restorative program by the DON. Resident 5's care plan has her nail care added to the Treatment Administration Record (TAR) for the nurses to complete on 5/15/24. All other resident's care plans will be reviewed and revised to incorporate documentation of nail care. CNA X will be re-educated by the DON or designee on documentation of nail care. All other staff responsible for giving baths will be re-educated to include documentation of nail care. * BS 5/20/24 Admin, DON and interdisciplinary team will review and revise the Care Planning Process policy. Admin or designee will audit the** ~~development of restorative programs~~ for 9 residents*** weekly for four weeks, then monthly for two more months.	06/09/2024 BS 5/20/24 BS 5/20/24

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F 656	Continued From page 20 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop, revise, and implement a comprehensive person-centered care plan that addressed nail care and range of motion for two of fourteen sampled residents (3 and 5). Finding Include: 1. Observation and interview on 4/23/24 at 9:19 a.m. with resident 3 revealed: *There was a picture on the wall with instructions on how to put on a right-hand splint and a schedule for the times that the splint was to have been put on. *Resident 3 indicated she had not worn that splint for a "long time." *She rested her right hand in her lap. *When asked to lift her arms she was unable to lift her right arm. *She stated, "No, none," when asked about range of motion exercises and if anyone helped her to move her arms. *She indicated that she: -Had been in therapy but was not currently. -Wanted an exercise program for her right arm. Interview on 4/24/24 at 2:35 p.m. with registered nurse (RN) N revealed that resident 3 only wore the hand splint at night, and "I don't know any	F 656	Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. * DON or designee will provide education to all staff responsible for the creation, review, and revision of resident care plans, including what topics should go into a care plan. ** care plans to reflect current health conditions *** or 25% of current residents, whichever is greater,	BS 5/20/24 BS 5/20/24 BS 5/20/24

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F 656	Continued From page 21 more about it." -That contradicted resident 3's report that she had not been wearing the splint. Review of resident 3's paper and electronic medical record (EMR) revealed: *An admission date of 5/24/22. *Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and contracture of muscle; right hand. *The most recent annual comprehensive Minimum Data Set (MDS) with an assessment reference date of 5/2/23 that indicated: -"Functional Limitation in Range of Motion: Upper extremity." -"Impairment on one side." -"She has worked with therapy in the facility but is currently doing restorative." *There was no current documentation in the EMR of a restorative program or use of the right-hand splint. *The Occupational Therapy Discharge Summary dated 9/26/23 indicated "Splint and Brace Program Established/Trained: Splint on at night off in the morning." Review of resident 3's care plan with a revision date of 5/19/23 revealed: *A goal of, "To voice adequate pain control and be able to participate in therapy." *An intervention of, "I have a contracture of my left hand r/t [related to] my CVA [cerebral vascular accident (stroke)]. I am working with OT [occupational therapy]." *The care plan had not been revised after discharge from occupational therapy on 9/26/23. *There were no goals or interventions related to her right-hand contracture.	F 656		

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F 656	Continued From page 22	F 656		

*There were no goals or interventions related to limited range of motion (ROM) of her right arm.

Interviews on 04/25/24 at 11:32 a.m. and again on 4/25/24 at 12:26 p.m. with administrator A revealed:
*She was unable to locate documentation on the use of a hand splint for resident 3.
*"I don't have anything on [resident 3's] splint, that would be OTR (registered occupational therapist) O."
*In reference to the sign hanging in resident 3's room, she stated, "I don't think the sign should be in her room, I will find out." She was unable to provide confirmation.
*They do not have a policy for the restorative nursing program.

2. Observation and interview on 4/23/24 at 11:34 a.m. with resident 5 revealed:
*She had long jagged, thickened fingernails with dark colored residue under the tips.
-The nails were brownish yellow in color and the growth was both upward and beyond the fingertip.
*She had a blue foam roll in her left hand.
*Both her left and right hands were resting in her lap with her fingers curled under.
*When asked to open her finger, she demonstrated minimal movement.
*She stated:
-She was "not happy" about not receiving exercises for her hands.
-"No one moves my hand."

Observation and interview on 4/23/24 at 9:45 a.m. and again on 4/25/24 at 10:03 a.m. with resident 5 revealed:
*She had a blue foam roll in her left hand.
*The foam roll had an unidentifiable substance on

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F 656	Continued From page 23 it. *Her fingernails remained long and there was an unidentified orange and brown substance under her nails. *She stated she liked to look nice. *Stated she wanted to get her "nails done on Thursday." Review of resident 5's EMR revealed: *An admission date of 6/24/19. *Diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side and weakness. *A physician order dated 7/8/23 for "Blue palm protector to right hand ON in AM off at HS one time a day for skin integrity of hand due to contracture and remove per schedule." *The most recent MDS significant change in status with an assessment reference date of 7/14/23 revealed: -"Functional Limitation in Range of Motion: Upper extremity ...Impairment on both sides." -"Functional Limitation in Range of Motion: Lower extremity ...Impairment on both sides." *There was no nail care or refusal of nail care documentation in the nurse's notes, care tasks, or Treatment Administration Record. Review of resident 5's care plan with a revision date of 10/19/23 indicated: *"I have history of a CVA." *"I have residual hemiplegia/hemiparesis to my left side." *"I have very limited ROM r/t my spinal stenosis and arthritis." *"I will maintain current level of function." -There were no interventions related to limited range of motion of her arms and legs. *"I like lipstick and to look nice ..."	F 656		

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	435080	A. BUILDING ______ B. WING ______	C 04/25/2024

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F 656	Continued From page 24 *She requires one person assistance with personal hygiene. *Skin assessments were to be completed weekly. *There were no goals or interventions related to her nail care. Interview on 4/25/24 at 9:38 a.m. with certified nurse assistant (CNA) X revealed: *Nail care was provided with scheduled baths once a week by the nursing assistants. -There was no specific nail care documentation to complete. "It's basic care." *Skin assessments were completed by the nurse on bath day. *The activities department provided a "nail class" on Thursdays each week. *She provided a bath to resident 5, but: -CNAs did not complete resident 5's nail care. -"A nurse does her nails, both toes and fingers." *Resident 5 "is not always receptive to baths or nail care." Interview on 4/25/24 at 9:31 a.m. with licensed practical nurse F revealed: *Resident 5 "goes to nail class on Thursdays with activities but sometimes refuses." *It was her expectation that: -"CNAs can care for [resident 5's finger] nails. -That was typically completed on bath days. Interview on 4/25/24 at 9:51 a.m. with activities director R revealed: *Resident 5 attended nail class "occasionally depending on her mood." *"We just polish or jewel her nails." *"We are careful about her nails." 3. Interview on 4/25/24 at 12:26 p.m. director of nursing (DON B) revealed:	F 656		

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F 656	Continued From page 25 *Residents 3 and 5 had not been assessed and was not receiving any restorative program. *Care plans were updated when MDSs were completed or when changes were identified. Review of the provider's Care Planning Process policy reviewed 10/27/21 and 4/25/24 revealed: *"To insure a comprehensive, individualized plan of care for each resident." *" ...each resident will have an individualized plan of care which addressed the resident's needs and severity of condition, impairment disability or disease ..." *"It is the responsibility of the IDT [interdisciplinary team] members to assess the resident, individualize the plan of care, evaluate the effectiveness and [of] the plan of care as a resident's needs change ..." Review of the "RAI [resident assessment instrument] Version 3.0 Manual" dated October 2023 revealed: *"Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan." *"The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving."	F 656		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range	F 688	Physician orders were obtained for PT and OT to evaluate and treat residents 3 and 5 for development of restorative programs and individualized restorative goals. All other residents will be reviewed for the need for a restorative program by the DON.	06/09/2024

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F 688	Continued From page 26 of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure an ongoing restorative nursing program for two of two sampled residents (3 and 5) at risk for a decline in range of motion. Findings include: 1. Observation and interview on 4/23/24 at 9:19 a.m. with resident 3 revealed: *There was a picture on the wall with instructions on how to put on a right-hand splint and a wearing schedule for that splint. -Resident 3 indicated she had not worn that splint for a "long time." *She rested her right hand in her lap. *When asked to lift her arms she was unable to lift her right arm. *She stated, "No, none," when asked about range of motion exercises and if anyone helped her to move her arms. *She indicated that she: -Had been in therapy but was not currently. -Wanted an exercise program for her right arm. Review of resident 3's paper and electronic medical record (EMR) revealed:	F 688	Administrator or designee will provide education to all staff about their roles and responsibilities for an active and ongoing restorative program to prevent a decline in residents' activities of daily living. DON or designee will audit * BS 5/20/24 ~~documentation and implementation~~ of the restorative programs* weekly for four weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review. BS 5/20/24 *the development BS 5/20/24 ** for 9 residents, or 25% of current residents, whichever is greater,	BS 5/20/24

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F 688	Continued From page 27 *An admission date of 5/24/22. *Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and contracture of muscle; right hand. *The most recent annual comprehensive Minimum Data Set (MDS) with an assessment reference date of 5/2/23 indicated: -"Functional Limitation in Range of Motion: Upper extremity." -"Impairment on one side." -"She has worked with therapy in the facility but is currently doing restorative." --There was no documentation to support her participation in a restorative program. *The care plan with a revision date of 5/19/23 indicated: -A goal of, "To voice adequate pain control and be able to participate in therapy." -An intervention of, "I have a contracture of my left hand r/t [related to] my CVA [cerebral vascular accident (stroke)]. I am working with OT [occupational therapy]." -No intervention related to her right hand contracture. *The 9/26/23 Occupational Therapy Discharge Summary dated indicated "Splint and Brace Program Established/Trained: Splint on at night off in the morning." *There was no documentation in the EMR of a restorative program or use of the right-hand splint. 2. Observation and interview on 4/23/24 at 11:34 a.m. with resident 5 revealed: *She had a blue foam roll in her left hand. *Both her left and right hands were resting in her lap with her fingers curled under. -When asked to open her fingers, she	F 688		

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F 688	Continued From page 28 demonstrated minimal movement. *She stated: -She was "not happy" about not receiving exercises for her hands. -"No one moves my hand." Review of resident 5's EMR revealed: *An admission date of 6/24/19. *Diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side and weakness. *A physician order dated 7/8/23 for "palm protector to right hand... for skin integrity of hand due to contracture... *The most recent MDS significant change in status with an assessment reference date of 7/14/23 revealed: -"Functional Limitation in Range of Motion: Upper extremity ...impairment on both sides." -Functional Limitation in Range of Motion: Lower extremity ...impairment on both sides." *The care plan with a revision date of 10/19/23 indicated: -"I have history of a CVA." -"I have residual hemiplegia/hemiparesis to my left side." -"I have very limited ROM [range of motion] r/t [related to] my spinal stenosis and arthritis." -"I will maintain current level of function." Interview on 4/25/24 at 8:48 a.m. with physical therapy assistant (PTA) P revealed: *She was familiar with both resident 3 and resident 5. *Neither of those resident were receiving skilled therapy. *In regards to a restorative nursing program she stated, "I believe they should both [resident 3 and resident 5] have a program."	F 688		

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F 688	Continued From page 29 -Those programs "would have been provided to [director of nursing (DON B)]." Interview on 4/25/24 at 10:50 a.m. with registered occupational therapist (OTR) O revealed: *Resident 3 was not currently receiving any skilled therapy services. *Resident 3 wore a hand splint and: -She stated, "I am not sure if she [resident 3] is tolerating it." --She was uncertain if resident 3 had a restorative program. *It was her expectation that if therapy recommended a splint schedule or restorative program when the resident was discharged from therapy, nursing would complete it or communicate if there was a problem. *Resident 5 was not currently receiving any skilled therapy services. *She was uncertain if resident 5 had a restorative program. *Restorative exercise and splinting programs, when written by a therapist, were given to (DON) B. Interview on 04/25/24 at 11:32 a.m. and again on 4/25/24 at 12:26 p.m. with administrator A revealed: *She was unable to locate documentation on the use of a hand splint for resident 3. *In reference to the sign hanging in resident 3's room, she stated, "I don't think the sign should be in her room, I will find out." She was unable to provide confirmation. *They do not have a policy for the restorative nursing program. Interview on 4/25/24 at 12:26 p.m. DON B revealed:	F 688		

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F 688	Continued From page 30 *Restorative is a nursing program she leads. *"Therapy involvement is limited to recommendation. Restorative programs will be modified by nursing." *"I don't need to communicate with therapy if I change the program that they wrote." *She had created a restorative User-Defined Assessment (UDA) in point click care (PCC) [the EMR software]. *Not every resident has been assessed yet using that UDA and: -As residents would come due for their annual MDS, she would evaluate the need for restorative programs and put them "back in place." -Residents 3 and 5 had not been assessed and did not have restorative programs.	F 688		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725	Unable to timely address resident 3, 4, 5, 13, and 21 call light records from February, March, and April of 2024. All residents have the potential to be affected by this deficient practice. Administrator, DON, and interdisciplinary team reviewed and revised as necessary the policy and procedure for staffing and the Call Light policy on 5/14/24 to ensure resident call lights are answered in a reasonable and acceptable time. DON or designee will provide education to supervisory and management staff to ensure the nursing department is sufficient in staffing levels to be able to sufficiently answer call lights in a reasonable and acceptable time.	06/09/2024

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F 725	Continued From page 31 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and policy review, the provider failed to ensure there were sufficient nursing staff to ensure call lights were answered in a reasonable time for five of thirty-five sampled residents (3, 4, 5, 13, and 21). Findings include: 1. Interview on 4/23/24 at 10:29 a.m. with resident 4 in his room revealed he: *Pointed out his pendant call light and stated its function. *Mentioned that sometimes he had to wait 20 to 30 minutes for someone to answer the call light. *Did not use the call light frequently. Review of resident 4's call light audit report from 2/24/24 to 4/24/24 revealed: *The report was generated from 2/24/24 to 4/24/24, but there was no data on the report before 4/5/24. *There were three call light wait times over 15 minutes. *The longest call light wait time was 40 minutes. 2. Interview on 4/23/24 at 11:01 a.m. with resident 3 about call light wait times revealed that she noticed she had to wait longer at nighttime.	F 725	Concerns related to insufficient staffing are tracked through the facility grievance process. A report of grievances will be communicated by the grievance official to the nursing staff and proper action is taken place. DON or designee will audit randomly competent residents to ensure sufficient staffing is addressed twice per week for four weeks and monthly for two more months. * DON or designee will present the audit findings at the monthly QAPI meetings for review. * In addition, Social Services or Designee will randomly audit call light wait times by triggering resident's call lights and record observations twice per week for four weeks and monthly for two more months. An analysis of these wait times will determine staffing shortages which will be used to implement actual changes.	BS 5/20/24 BS 5/20/24

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F 725	Continued From page 32 Review of resident 3's call light audit report from 2/24/24 to 4/24/24 revealed: *There were 19 call light wait times over 15 minutes. *The longest call light wait time was 30 minutes. 3. Interview on 4/23/24 at 11:41 a.m. with resident 5 revealed that she sometimes waited for "hours" for someone to come help her at night when she used her call light. Observation on 4/23/24 at 11:48 a.m. revealed that resident 5's call light was not functioning. -When the button was pressed it did not show up on call light report. -It was discovered that the battery needed to have been replaced. Review of resident 5's call light audit report from 2/24/24 to 4/24/24 revealed there was one time on the evening of 4/22/24 where her call light wait time was 40 minutes. 4. Interview on 4/23/24 at 2:30 p.m. with resident 21 in her room revealed she: *Was there for therapy after she fell at home and broke her hip. *Had to wait long periods of time for staff to help her, but she did not keep track of how long she waited. *Was not supposed to stand up on her own but did that anyway because "when you have to go, you have to go." *Was incontinent at times because she could not make it to the bathroom in time. *Was able to sense when she needed to use the restroom. *Wore incontinent briefs for "the occasional accident."	F 725		

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Review of resident 21's call light audit report from 4/8/24 to 4/24/24 revealed:
*There were 25 call light wait times over 15 minutes.
*The longest call light wait time was 109 minutes.
*Specific long call light wait times that correlated to her incontinence episodes were as follows:
-4/11/24, call light triggered at 12:30 p.m., alarm cleared at 1:00 p.m. after 30 minutes.
-4/19/24, call light triggered at 4:02 a.m., alarm cleared at 4:25 a.m. after 23 minutes.
-4/20/24, call light triggered at 7:05 a.m., alarm cleared at 7:28 a.m. after 23 minutes.

Review of resident 21's bladder incontinence records revealed she was incontinent on the following dates and times:
*4/11/24, 4:37 a.m.
*4/13/24, 7:49 p.m.
*4/14/24, 9:05 p.m.
*4/17/24, 5:06 a.m.
*4/19/24, 4:59 a.m.
*4/21/24, 8:21 p.m.

Review of resident 21's bowel incontinence records revealed she was incontinent on the following dates and times:
*4/10/24, 6:19 a.m.
*4/11/24, 1:58 p.m.
*4/20/24, 8:56 a.m.
*4/21/24, 8:21 p.m.

Review of resident 21's 4/11/24 admission Minimum Data Set assessment revealed she was occasionally incontinent of urine and frequently incontinent of bowel.

Interview on 4/24/24 at 3:35 p.m. with licensed

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practical nurse (LPN) F about bowel and bladder incontinence charting revealed:
*Some staff chart on a resident's continence right away after assisting that resident, while others chart later.
*They would write quick notes on the pocket care plan to chart on later.

Interview on 4/24/24 at 3:44 p.m. with certified nurse aide (CNA) W about charting revealed that she usually wrote whether the resident was continent or incontinent on the pocket care plan, and then charted later.

Interview on 4/24/24 at 4:10 p.m. with business office manager/CNA J revealed:
*He usually assisted on the floor during busier times.
*If he assisted residents to use the bathroom and noted that they were continent or incontinent, he charted later.

Interview on 4/25/24 at 2:23 p.m. with resident 21 revealed she:
*Confirmed she was able to sense when she needed to use the bathroom.
*Wore an incontinence brief for the occasional accident.
*Confirmed she had a few accidents where she could not make it to the bathroom in time because she had to wait too long for staff to assist her to the bathroom.
*Indicated some staff were quicker to respond than others.

Interview on 4/25/24 at 3:14 p.m. with administrator A about resident 21 revealed:
*When she admitted on 4/8/24, she was more incontinent of bowel than she was now due to

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adverse side effects of some medications.
*Her physician stopped that medication and her incontinence improved.
*She was aware of some of the longer call light wait times on resident 21's call light audit report.
-She said, "I hope it's just because they [the staff] forgot to turn the call light off."

5. Interview on 4/23/24 at 4:18 p.m. with resident 13's daughter revealed she:
*Visited her mom frequently.
*Noticed longer call light wait times, usually around 30 minutes.

Review of resident 13's call light audit report from 2/24/24 to 4/24/24 revealed:
*There were 19 call light wait times over 15 minutes.
*The longest call light wait time was 46 minutes.
*The resident's call light stopped functioning on 3/29/24 around 7:00 p.m.
*The resident was given a different call light on 3/31/24.

Interview on 4/24/24 at 10:29 a.m. with CNA E about resident call lights revealed:
*There were a few different styles of call lights used.
-A portable button.
-A corded button attached to the wall.
-A paddle button attached to the wall.
*All types of call lights were connected to the staff radios.
*When a resident pressed their call light, the staff's radio would audibly announce which room number needed assistance.

6. Interview on 4/24/24 at 1:00 p.m. with the resident council revealed:

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	435080	A. BUILDING ______ B. WING ______	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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F 725	Continued From page 36	F 725		

*It was harder to get staff to answer the call lights in the evening.
*One resident stated he often waited in bathroom for 30 minutes for staff to answer his call light.
-He stated that he recently waited on the toilet for 45 minutes.
*Another resident stated she called the facility on her cell phone when she had to wait more than 20 minutes.
*The residents stated, "We have to be patient in the evening or morning."

7. Interview on 4/25/24 at 3:15 p.m. with administrator A about the long call light wait times revealed:
*She was aware of the long call light wait times.
*She performed a call light audit at the beginning of the month and noticed longer call light wait times in the morning around shift change.
*She confirmed the night shift staff consisted of one CNA and one nurse from 10:00 p.m. to 6:00 a.m.
*They changed the morning shift process to get the CNAs onto the floor sooner to assist the residents with getting up for the day.
*The night shift ended at 6:15 a.m., and the morning shift started at 5:45 a.m. which allowed for a 30-minute overlap between shifts to provide time for the shift-to-shift reports.

8. Review of nursing staff schedules for March and April 2024 confirmed the day-to-day staffing pattern consisted of the following for a maximum of 35 residents:
*From 10:00 p.m. until about 5:45 a.m. the next morning, there was only one nurse and one CNA scheduled.
*One daytime charge nurse from 5:45 a.m. to 6:15 p.m.

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F 725	Continued From page 37 *One daytime treatment nurse from 5:45 a.m. to 6:15 p.m. *Three daytime CNAs from 5:45 a.m. to 2:00 p.m. *One daytime CNA from 5:45 a.m. to either 4:00 p.m. or 6:15 p.m. *Anywhere from two to four evening CNAs from 2:00 p.m. to 10:00 p.m. *One evening medication aide from 5:45 p.m. to 10:00 p.m. *One night CNA from 5:45 p.m. to 6:15 a.m. *One night nurse from 5:45 p.m. to 6:15 a.m. Review of the provider's revised 4/24/24 Call Light policy revealed: *"Purpose: -To assure that resident always has a method of calling for assistance. -To promptly answer the resident's call." *"Procedure: -1. When resident's call light is observed, go to resident's room promptly. -2. Turn call light off and inquire about resident's request in a friendly manner and respond as soon as possible. -3. When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it." *The policy did not define an acceptable time frame to answer call lights.	F 725		
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	F 761	All residents have the potential to be affected by this deficient practice. Admin, DON, and interdisciplinary team reviewed and revised the Storage of Medications policy and procedure on 5/14/24.	06/09/2024

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

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F 761	Continued From page 38 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: Based on observation, interview, record review, and policy review, the provider failed to ensure expired medications were not administered to residents, and removed and discarded for nine of thirty bulk medications in two of two medication carts. Findings include: 1. Observation on 4/25/24 at 10:20 a.m. of the 200/300 hallway medication carts with licensed practical nurse (LPN) F revealed there were several bulk medications that were past the manufacturer's expiration dates: *A bottle of Senna with an open date of 8/6, and an expiry date of 1/2024. *A bottle of TUMS, there was no open date or expiry date noted.	F 761	DON or designee will re-educate RN K, LPN F and all other staff responsible for medication administration to ensure medications are properly dated when opened, check expiration date, and discard expired medications from active supply. DON or designee will audit the medication cart and medication room for medication that has been opened, properly dated, checking expiration dates of current medications, and discarding expired medications from active supply once per week for four weeks and monthly for two more months. * DON or designee will present the audit findings at the monthly QAPI meetings for review. * Pharmacist to be included in reviewing expired medications and providing input to the on-going audits.	BS 5/20/24 * BS 5/20/24

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F 761	Continued From page 39 *A bottle of multivitamins with an open date of 2/10/23 and a "Best if Used By" date of 3/2024. *A bottle of calcium tablets with an open date of 12/29/22, and an expiry date of 12/22/23. *A bottle of aspirin with an open date of 6/26/23 and an expiry date of 2/2024. 2. Observation on 4/25/24 at 10:55 a.m. of the 100/400 hallway medication cart with registered nurse K revealed: *An open bottle of TUMS, there was no open date, the expiry date was 6/2025. *An opened bottle of Milk of Magnesia, there was no open date, the expiry date was 4/2025. *A bottle of Tylenol with an open date of 4/10/24 and an expiry date of 3/2024. *A bottle of Senna with an open date of 3/2024 and an expiry date of 1/2024. 3. Interview on 4/25/24 at 10:40 a.m. with LPN F revealed: *She confirmed the written dates with a black Sharpie were the dates the bottles were opened to administer the medications to the residents. -Clearly, some expired medications were missed and left on the cart. -The pharmacist would come into the facility and audit the medications in the store room and the medication carts monthly. -Nurses should be checking for expiration dates before administering medications and if the medications were expired they should have removed them from the cart and prepared them for disposal. 4. Interview on 4/25/24 at 10:55 a.m. with registered nurse (RN) K revealed: *She confirmed the written dates with black Sharpie were the dates the bottles were opened	F 761		

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F 761	Continued From page 40 and administered to the residents. -Some of those medications were outdated and should have been removed from the medication cart. -"We use Milk of Magnesia up so fast it would not last until its expiration date." -Nurses should verify the expiration date before administering medications to the residents. 5. Interview on 4/25/24 at 11:30 a.m. with Administrator A revealed: *The director of nursing was out with a sick child. -Outdated medications should be disposed of and not used. *She thought the pharmacist had recently been on site to do the audit, "but, I will just own it and move on." 6. Review of the provider's 4/25/24 policy and procedure for Storage of Medications policy revealed: *Medications labeled for individual residents were stored separately from the floor-stock medications. *Outdated medications were disposed of according to procedures for medication disposal. *Medication storage conditions were monitored on a monthly basis by the consultant pharmacist or pharmacy designee. *If drugs dispensed in the manufacturer's container or vial was initially broken, the container or vial would have been dated. -The nurse would place a date opened on the medication. -The expiration date of the vial or container would have been 30 days unless the manufacturer recommends another date or regulations/guidelines required different dating. -The nurse would check the expiration date of	F 761		

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F 761	Continued From page 41 each medication before administering it. *No expired medications should have been administered to a resident. *All expired medications should have been removed from the active supply and destroyed in the facility, regardless of the amount remaining.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure necessary food safety guidelines were implemented and followed for appropriate storage and labeling of food and chemical items, appropriate monitoring of the low-temperature dishwasher, and cleaning and sanitary maintenance of one of one kitchen.	F 812	Unable to timely document the missing concentration measurements in April. All residents have the potential to be affected by this deficient practice. Admin, DON, and interdisciplinary reviewed and revised the Food Preparation/Food Storage Policy on 5/14/24 and a cleaning checklist was created for routine and general cleaning tasks to eliminate areas including, but not limited to of dust, food particles, dirt, grime, debris, rust or chemical discoloration layering on any surface. Admin or designee will re-educate DM C and all other staff responsible for food preparation receiving and dating of canned fruits and vegetables, testing sanitizer concentration on dishwasher, usage of hairnets, recovering measuring cups, bottled chemicals, and a cleaning checklist was created on 5/14/24 for routine and general cleaning tasks to eliminate areas including, but not limited to of dust,	06/09/2024

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F 812	Continued From page 42 Findings include: 1. Observation on 4/23/24 at 8:26 a.m. during the initial kitchen tour revealed: *There were approximately 35 cans of fruits and vegetables in the dry storage room with no manufacturer's date and no date when those food items were received. *There were four dented cans in the dry storage room. *The chemical sanitizer monitoring sheet for the low-temperature dishwasher was missing concentration measurements for the following dates: 4/2/24, 4/6/24, 4/7/24, 4/9/24, 4/12/24, 4/16/24 4/19/24, 4/20/24, 4/21/24, and 4/23/24. *The chlorine testing strips for testing the dishwasher chemical sanitizer concentration had an expiration date of September 1, 2023. *A bottle of liquid bleach disinfecting cleaner and two spray bottles of degreaser were sitting next to the stand mixer in the kitchen preparation area. *The ceiling vent in the dry storage room was covered with dust and grime. *The stand mixer had crusty food particles and flour on the backsplash of the mixer. -The mixer was not covered with a protective stand cover. *There was a bucket with standing water and unidentified food particles scattered beneath the plumbing pipes of one of the prep sinks. -The pipe was held up by a bungee cord. *The bottom of the convection oven had burnt food on the bottom of the oven surface. *Dust was caked behind the oven and on the top of the stove. *The ice dispenser in the dining room had a thick layer of hard water sediment around the dispenser spout, the catch grate beneath, and on the counter around the ice machine.	F 812	grime, debris, rust or chemical discoloration layering on any surface. Admin or designee will re-educate DM C and all other staff responsible for food preparation receiving and dating of canned fruits and vegetables, testing sanitizer concentration on dishwasher, usage of hairnets, recovering measuring cups, bottled chemicals, and a cleaning checklist was created on 5/14/24 for routine and general cleaning tasks to eliminate areas including, but not limited to of dust, food particles, dirt, grime, debris, rust or chemical discoloration layering on any surface. Admin or designee will re-educate MD D on ice machine cleaning and servicing will be included on the preventative maintenance semi-annual checklist.* Maintenance will repair the pipe under the prep sink. Any food or drink item that was undated was discarded as well as any unused leftovers past 72 hours. Admin or designee will audit the receiving and dating of canned fruits and vegetables, testing sanitizer concentration on dishwasher, usage of hairnets, recovering measuring cups, bottled chemicals, and a cleaning	BS 5/20/24

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F 812	Continued From page 43 *There was food build-up on the inside of the dishwasher doors. *Ceiling vents throughout the kitchen were dusty and covered with unidentified dark matter. *Chains above the food preparation counter that held utensils were dusty and covered with cobwebs. The serving ladles were placed directly beneath those chains and were covered with a layer of dust and grime. *The floor drain that was by the refrigerator had a green discoloration. *One measuring cup was stored inside the flour bag in a storage container. *The refrigerator floor under the shelves had a build-up of an unidentified brown substance. -A bottle of grape juice with a "best used by April 12, 2024," in the refrigerator. -Strawberry sauce dated 3/20 was in the refrigerator. -Sauerkraut dated 3/18 was in the refrigerator. -Three glasses of undated tomato juice. -Sliced cheese wrapped in plastic wrap that was undated. 2. Observation and interview with 4/24/24 at 3:40 pm with dietary cook I revealed: *The sink leaks when the lid to the garbage disposal was used. -The bin stopped water from leaking on the floor. *The maintenance director (MD) D was responsible for cleaning the ice dispenser. -She would run hot water down the drain every day that she worked to clean the ice tray. 3. Interview on 4/25/24 at 9:57 a.m. with administrator (ADM) A revealed: *There were no cleaning policies or consistent schedules for cleaning the kitchen. *There was no ice dispenser cleaning log.	F 812	checklist for routine and general cleaning tasks to eliminate areas including, but not limited to of dust, food particles, dirt, grime, debris, rust or chemical discoloration layering on any surface once per week for four weeks and monthly for two more months. Admin or designee will present the audit findings at the monthly QAPI meetings for review. * MD to clean and/or repair the countertop under the dining room ice machine.	BS 5/20/24

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F 812	Continued From page 44	F 812		

*MD D overseen the cleaning of the ice dispenser.

4. Observation on 4/25/24 at 11:30 a.m. of dietary manager (DM) C revealed that he was prepping and handling food without wearing a beard net to cover his facial hair.

5. Interview on 4/25/24 at 1:57 p.m. with DM C revealed:
*He usually returned dented cans to the food supplier.
*He was not aware that the cans of food did not have a manufacturer's expiration date.
-He had never thought to date cans when they were received.
*There were no cleaning schedules for the kitchen.
*He was unaware that the chlorine testing strips were expired.
*Scoops were not to have been left in food storage containers.
*There was a policy for the use of hairnets and hairnets were to have been worn when working in the kitchen.
-There were hairnets and beard nets available.
-He thought that his beard was trimmed enough that he would not need to wear a beard net.

6. Interview on 4/25/24 at 2:45 p.m. with MD D and ADM A revealed:
*The policy was to clean the ice dispensers twice a year.
*They confirmed the ice dispensers, had not been cleaned in the last six months.
-There were no cleaning logs for the ice dispensers.
-They were aware of the hard water build-up under the ice dispenser in the dining room.

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F 812	Continued From page 45 7. Review of the provider's 4/24/24 Sanitation of Dietary Department policy revealed the dietary staff should maintain the sanitation of the dietary department through compliance with a written and comprehensive cleaning schedule. Review of the provider's 4/24/24 Leftovers policy revealed: *All leftovers should have been properly covered and labeled with the name of the product and the date it was prepared. *Refrigerated leftovers should be used within 72 hours. *Items that cannot be used in 72 hours should have been placed in the freezer. Review of the provider's 4/24/24 Food Preparation/Food Storage Policy revealed: *"The principles of "first in, first out" (FIFO) will be used on all areas of food storage for rotation of food items. Refer to state regulations regarding dating of stock. (Dating can assist in demonstration of FIFO[first in, first out])" *"Foods which have been opened or prepared will be placed in an enclosed container, dated, and labeled. (See policy and procedure on leftovers). Cover, date, and label trays of individually poured items such as glasses of juice, milk, supplements." *"Expiration dates will be checked on a regular basis and food and fluids which have expired will be discarded. Potentially hazardous foods will be discarded after three days in refrigerator." *"Chemicals will not be stored near food items." Review of the 4/24/24 provider's user manual for low temperature dishwasher policy revealed: *"Dishwasher for ADS (American Dish Service)	F 812		

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F 812	Continued From page 46 AF-C Policy revealed sanitizer should be 6% solution of sodium hypochlorite [a chemical sanitizer]." *"The initial setting is 5cc [cubic centimeter] and this should be checked regularly with a chlorine test kit. Free chlorine in the final rinse should be 50 ppm or more. However, high concentrations can cause deterioration of metal." Review of provider's undated maintenance and cleaning ice machine policy for the ice dispenser revealed maintenance and cleaning should be scheduled at a minimum of twice per year.	F 812		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping).	F 851	Unable to timely correct past staffing data into PBJ (Payroll Based Journal) entries for Quarter 1, 2024, Quarter 3, 2023, Quarter 2, 2023. All residents have the potential to be affected by this deficient practice. Admin or designee will re-educate new office manager J the importance of correctly inputting staffing records into PBJ so infractions do not trigger false alarms.* Admin or designee will audit the effectiveness of staffing entries using the CASPER Report 1705D when it becomes available once per quarter for two quarters. Admin or designee will present the audit findings at the monthly QAPI meetings for review.	06/09/2024 BS 5/20/24

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F 851	Continued From page 47 §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff	F 851	* An attempt to reach out to PBJ to authorize the facility to correct past quarters staffing records to correct any triggers.	BS 5/20/24

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F 851	Continued From page 48	F 851		

schedule and timecard review, and interview, the provider failed to ensure Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the care of the residents) data was accurately completed before submission to the Center for Medicare and Medicaid Services (CMS) for three of four federal fiscal quarters (Quarter 2, 2023; and Quarter 3, 2023; and Quarter 1, 2024).
Findings include:

1. Review of the PBJ data submitted to CMS for the three quarters listed above revealed:
*The following items were triggered:
-Excessively low weekend staffing (Quarter 3, 2023 only).
-Failed to have licensed nursing coverage 24 hours per day.
*The infraction dates for failing to have licensed nursing coverage 24 hours per day was as follows:
-Quarter 1, 2024 (October 1, 2023, to December 31, 2023): 10/7/23, 10/16/23, 11/18/23, 11/23/23, 11/27/23, 12/9/23, 12/16/23, 12/19/23, 12/23/23, 12/25/23, and 12/26/23.
-Quarter 3, 2023 (April 1, 2023, to June 30, 2023): 4/1/23, 4/5/23, 4/6/23, 4/7/23, 4/8/23, 4/9/23, 4/14/23, 4/19/23, /22/23, 5/6/23, 5/29/23, 6/24/23, and 6/30/23.
-Quarter 2, 2023 (January 1, 2023, to March 31, 2023): 1/1/23, 1/11/23, 1/13/23, 1/18/23, 1/28/23, 1/30/23, 2/4/23, 2/13/23, 2/18/23, 2/22/23, 2/23/23, 2/28/23, 3/1/23, 3/8/23, 3/10/23, 3/11/23, 3/13/23, 3/19/23, 3/23/23, 3/24/23, 3/25/23, 3/26/23, 3/27/23, 3/28/23, 3/29/23, and 3/31/23.

2. Review of the provider's 2023 employee staffing schedules and timecards revealed they had licensed nursing coverage 24 hours per day

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F 851	Continued From page 49 on the dates listed above. 3. Interview on 4/25/24 at 4:08 p.m. with administrator A regarding the PBJ staffing data revealed: *She confirmed the staffing schedules were correct and they had met the requirement to have licensed nursing coverage for 24 hours per day. *She was not aware that the staffing data had been inaccurately submitted to CMS. *The former business office manager was responsible for submitting the staffing data. -That employee stopped working for the facility in October 2023. *She speculated that the former employee had been submitting the staffing data incorrectly. *She was unsure why the most recent quarter's staffing data was incorrect.	F 851		
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	All residents have the potential to be affected by this deficient practice. Admin, DON, an interdisciplinary team will implement a program for prevention of legionella and other waterborne pathogens. A risk assessment for control sources will be identified based off the CDC (Center for Disease Control) toolkit. The water management team will perform and document specific testing for prevention of legionella. A plan for annual review of the infection control policies will also include the Water Management – Legionella. Admin will audit the effectiveness of the water management program by	06/09/2024

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F 880	Continued From page 50 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	monitoring the validation of routine maintenance checks and that they are documented per facility protocol once per week for four weeks and monthly for two more months. Admin or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 880	Continued From page 51 §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 interview and policy review, the provider failed to ensure that Legionella monitoring and prevention were addressed in the infection control program, which had the potential to affect all 35 residents within the facility. Findings include: 1. Review of the provider's 10/27/21 infection prevention and control program revealed there was nothing related to the prevention and monitoring of Legionella. 2. Interview on 4/25/24 at 8:15 a.m. with administrator A about the provider's Legionella program revealed: *She was not aware of any water testing for Legionella. *Director of nursing B was the infection preventionist, but she was not present in the facility for an interview. *Maintenance director D might know more about the Legionella monitoring. Interview on 4/25/24 at 11:31 a.m. with maintenance director D about Legionella revealed: *He did not perform any testing on the facility's water supply. *They were connected to the city's municipal	F 880		

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F 880	Continued From page 52 water system. *He contacted the city's municipal water department and learned they did not monitor for Legionella. -They only monitored the pH of the water supply, not the concentration of chlorine sanitizer necessary to prevent the growth of Legionella bacteria. *He confirmed the water had not been tested in the three years he had been working at the facility. Interview on 4/25/24 at 3:29 p.m. with administrator A revealed she confirmed they had no Legionella monitoring or prevention plan as part of the facility's infection control program.	F 880		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the regular safety inspection of bed rails for two of two sampled residents (2 and 7). Findings include: 1. Observation and interview on 4/23/24 at 8:49 a.m. with resident 7 revealed: *She had bed rails on the bed in the up position.	F 909	Admin, DON and interdisciplinary team reviewed and revised the Bed Inspection and Bed Rail Policy and created a bed rail safety assessment on 5/15/24 to ensure all areas of possible entrapment are identified. Admin or designee will re-educate the maintenance supervisor on the bed inspection and bed rail policy. Resident 2 and 7 will have bed rail safety assessments completed by the maintenance supervisor. All other residents using bed rails will have a safety assessment completed by the maintenance supervisor. Admin or designee will audit the bed rail safety assessments are completed	06/09/2024

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F 909	Continued From page 53 -She stated she had a stroke 5 years ago and could not use her right leg or arm. -She said she used the bed rails sometimes for repositioning, otherwise, they are just there. Interview with CNA X revealed: *Resident 7 used thebed rail at night, but she never observed her using them. 2. Observation and interview on 4/23/24 at 9:24 a.m. with resident 2 revealed: *She was sitting in her wheelchair in her room while CNA Y made her bed. *Resident 2 would not respond when questioned about the use of the rail. -There was one bed-rail on her bed that was near the wall. -CNA Y stated the resident did not use the bed rail. 3. Interview on 4/25/24 at 10:15 a.m. with maintenance director D revealed he: *Did not assess the bedrails. -Did not have measurements or any log with bedrail information. -Would put the bedrails on the bed when he received a physician's order. -Did not do annual checks or monitoring of those bed rails once they are placed on the residents bed. 4. Review of the providers undated Bed Inspection and Bed Rail Policy revealed: *It was the policy of the facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach would be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) individual bed rail	F 909	for all residents using bed rails once per week and monthly for two more months. Admin or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 909	Continued From page 54 evaluations. In response to the requirement of providing for a "safe, clean, comfortable, and homelike environment," the facility's regular maintenance program would include regular inspection of all bed systems (e.g. rails, frames, and mattresses, and operational components) to ensure they were clean, comfortable, and safe. The facility would also ensure individual resident bed rail evaluations were performed on a regular basis. Individual bed rail evaluations would include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) were deemed necessary and appropriate, the facility would provide education to resident or resident's representative pertaining to the risks and benefits of bed rail use. The facility's priority was to ensure safe and appropriate bed rail use. -The objective of the bed rail use policy is to determine if resident use was safe and appropriate. The interdisciplinary team would use data collected from regular bed inspections and individual bed rail evaluations to bolster care planning and positive resident outcomes. The bed rail use policy would be reviewed annually or more frequently as needed and would be integrated into the facility quality assurance and performance program.	F 909		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from-	F 919	Unable to timely address past period call light problems with resident 5 and 13. All residents have the potential to be affected by this deficient practice. Admin, DON, and Interdisciplinary team reviewed and revised the Call light policy to include the procedure of what staff are expected to do if	06/09/2024

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F 919	Continued From page 55 §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, resident and family interview, call light audit review, and policy review, the provider failed to ensure the resident call light system was functioning for 2 of 13 sampled residents (5 and 13) out of 35 total residents. Findings include: 1. Observation and interview on 4/23/24 between 11:34 a.m. and 11:41 a.m. with resident 5 in her room revealed: *At times she waited "hours at night for someone" to assist her when she used her call light. *The blue call button was pushed at 11:41 a.m. -The red indicator light was not activated. -There was no indication outside the room that the resident's call light was on. Observation and interview on 4/23/24 at 11:48 a.m. with certified nurse assistant (CNA) Y revealed: *She walked past resident 5 ' s room for a second time. *When asked if resident 5 ' s call light was activated, she stated that the call light was not currently activated on her "walkie [walkie-talkie]." -She carried the "walkie [walkie-talkie]" in her pocket, and it audibly announced which room number was calling. --It repeated that information until it was cleared by pressing the orange button on the call light. *Upon entering resident 5's room she attempted to activate the call light and stated, "It's not on my walkie [walkie talkie]...the red light should be on. The batteries could not be working."	F 919	the call light was malfunctioning. * Admin or designee will provide education to all staff regarding call light function and completing work orders. Admin or designee will conduct random audits for call light functionality and timeliness for 9 rooms per week and monthly for two more months. Admin or designee will present the audit findings at the monthly QAPI meetings for review. *Will work with call light vendor and/or our IT department as to what is causing the system crashes and how to mitigate this issue.	BS 5/20/24 BS 5/20/24

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F 919	Continued From page 56	F 919		

*She stated she would not know if the call light was not working unless someone told her.
*She explained that there was a maintenance book to let maintenance know when things were broken.
*She assisted resident 5 out of her room.
*She took the call light box to maintenance "now and get it fixed right away."

Observation and interview on 4/24/24 at 10:18 a.m. with licensed practical nurse F revealed:
*She arrived at resident 5 ' s room because the call light had been activated.
-Had heard the call light activation on her "walkie [walkie-talkie]."
*She confirmed that the red light was not lit.
-Stated that it "should be lit [indicating the call light was activated] because it was on her "walkie."
*When asked how she would know the call light was broken, she said "Someone would have to say they called, and no one answered."
*She changed the batteries herself at times when the call lights were not working.

Review of resident 5's call light audit report revealed the following:
*There was no indication that the batteries were low.
*There was no record of the call light having been activated when the call light button was pressed on 4/23/24 at 11:41 a.m.
*The call light started working again at 11:59 a.m.

2. Interview on 4/23/24 at 4:18 p.m. with resident 13's daughter revealed:
*She was visiting resident 13 recently and the call light was not working.
-They pressed the button, but nothing happened.

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F 919	Continued From page 57 -After waiting for some time, she went to find a staff member for help. *The staff member discovered at that time that resident 13's call light had stopped working. *They had given resident 13 a different call light that was functioning properly. Interview on 4/24/24 at 10:21 a.m. with resident 13 revealed: *She remembered when her call light stopped working a couple of weeks ago. *Staff had given her a different call light to use. Interview on 4/24/24 at 10:29 a.m. with CNA E regarding resident call lights revealed: *When a resident pressed the call light, the staff's radio would announce which room number needed help. *There was an alarm in the CNA room that alerted when a portable call light's battery was low. *They were not able to reassign the call light room number if they had to give a resident a new call light. -For example, resident 13 had the call light assigned to room 110, even though resident 13 was not in room 110. -The radio would announce that room 110 needed help if resident 13 pressed her call light. -Staff would write down what resident had which call light on a piece of paper or sticky notes attached to the call light computer in the CNA room. *She agreed that the system could have been confusing since several residents were using call lights that were not assigned to their room numbers. Interview on 4/24/24 at 1:12 p.m. with	F 919		

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F 919	Continued From page 58 administrator A regarding resident call lights revealed: *She received a text on 3/31/24 stating that resident 13's call light was not working. *She instructed staff to give the call light assigned to room 110 to resident 13. *Based on call light audits, resident 13's call light potentially stopped working on 3/29/24. *Resident 13 was still using the call light assigned to room 110. *She could reassign room numbers in the call light system computer program so that each resident's call light would match their room number. -However, the call light system computer program was not reliable and would crash each time she reassigned a room number. -That caused the entire call light system to malfunction and turn off. *She explained that if she had a list of 10 resident call lights to reassign, the program would crash and restart 10 times. -That caused residents and staff to become upset and stressed because the call light system would be nonfunctioning for an uncertain amount of time. *She did not know which company provided the call light system computer software. -At one point, they had a computer programmer examine their call light computer, but they were unable to fix it. *She confirmed there was no regular preventative maintenance for the resident's call lights. *After the malfunctioning call light incident with resident 13, she conducted a facility-wide audit from 4/3/24 to 4/5/24. -She replaced some call lights because they were not working properly. *Staff contacted her directly if they noticed a	F 919		

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F 919	Continued From page 59 resident's call light button was broken, and she would instruct them what to do, or she would fix it herself. *Sometimes, staff reported a malfunctioning call light button in the maintenance request book. Interview on 4/25/24 at 10:19 a.m. with maintenance director D regarding the call lights revealed: *They did not have a preventative maintenance program for the call lights. *If a call light was malfunctioning, the staff informed him verbally and he would fix it right away. *He replaced the batteries in the call lights. Review of resident 13's call light audit report from 2/24/24 to 4/24/24 revealed: *She had been using a call light with the "Remote ID" of "38-5-100." *A "Low Battery" signal was transmitted on 3/28/24 at 5:30 p.m. *The resident's call light stopped functioning on 3/29/24 around 7:00 p.m. *The resident was given a different call light with the "Remote ID" of "38-4-251." -She first used that call light on 3/31/24 at 2:24 p.m. 3. Review of the provider's Maintenance Requisition from 12/15/23 through 4/22/24 revealed: *12/15/23, "107 call light not working." That request was not recorded as having been completed. *12/17/23, "119 call light unhooked." That request was not recorded as having been completed. *4/19/24, "Rm [Room] 202 BR [bathroom] call light doesn't work."	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING ______ B. WING ______	C 04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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F 919	Continued From page 60 Review of the provider's revised 4/24/24 Call Light policy revealed: *There was no procedure on what staff were expected to do if a call light was malfunctioning. *There was no description of regular preventative maintenance checks for the call lights.	F 919		

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

PRINTED: 05/08/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING ____ B. WING ____	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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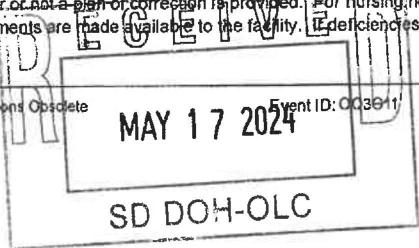
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 4/23/24 through 4/25/24. Bethesda of Beresford was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature]

TITLE: Administrator

(X6) DATE: 05/10/2024

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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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
	435080	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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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 4/23/24. Bethesda of Beresford 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 — [signature]
TITLE: Administrator
(X6) DATE: 05/16/24

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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MAY 17 2024
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PRINTED: 05/08/2024
FORM APPROVED

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
	10595	A. BUILDING: ______ B. WING ______	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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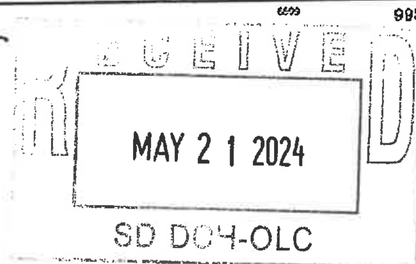
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/23/24 through 4/25/24. Bethesda of Beresford was found not in compliance with the following requirements: S195, S206, and S301.	S 000		
S 195	44:73:03:02 General Fire Safety Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its 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 shall be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to sound the fire alarm monthly for calendar year 2023 (August and September). Findings include: 1. Record review at 12:45 p.m. on 4/23/24 revealed documentation the fire alarm was not sounded in August and September of 2023. Those months' fire drill sheets stated the alarm was not sounded (Silent Drill) and the portion of the form for when the alarm was sounded another time during the month had been left blank. Interview with the maintenance director at the time of the record review confirmed that finding.	S 195	Unable to correct the noncompliance for the missing documentation for August and September of 2023 sounded fire drill. Fire policy and procedure will be reviewed and revised as necessary to ensure monthly sounded drills are conducted as required. Maintenance director and all other staff responsible for conducting fire drills will be re-educated by the Admin for monthly sounding of the fire alarm will be performed and documented. Administrator or designee will audit sounded fire alarms monthly for 6 months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	06/09/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Administrator | (X6) DATE: 05/10/24

[signature] Administrator 05/21/24



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10595	A. BUILDING: ______ B. WING ______	04/25/2024

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S 195	Continued From page 1 He stated They must have missed those months.	S 195		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by:	S 206	The facility will review and revise the formal orientation program and the ongoing education program for all employees which cover the required subjects on an annual basis and include the required topic of incidents and disease subject to mandatory reporting. Administrator and all staff responsible for hiring personnel will be re-educated on the initial orientation and ongoing, annual program. Administrator or designee will provide education to employees G, H, Q, S, and T to ensure completion of the required annual training of the 11 subjects. All other employees will be reeducated for proper completion of the annual training of the 11 subjects. Administrator or designee will audit employee files to ensure the required training occurs for all staff on payroll ~~weekly for 4 weeks and~~ BS 5/20/24 monthly for ~~two~~* months. * six BS 5/20/24 Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	06/09/2024

South Dakota Department of Health

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S 206	Continued From page 2 Based on review of employee, employee training records, and interview, the provider failed to ensure mandatory training was provided on all the required training subjects for five of five sampled employees (G, H, Q, S, and T) hired between 7/17/23 and 1/23/24. Findings include: 1. Review of the employee files and training records for employees G, H, Q, S, and T revealed they had not received training during orientation regarding incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. Interview on 4/25/24 at 11:32 a.m. with administrator A revealed: *She was not aware that incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms was a required topic. *They had not offered training on those topics during orientation nor the annual ongoing education.	S 206		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review, dietary training packet review, and interview, the provider failed	S 301	The facility will review and revise the formal orientation program and the ongoing education program for all employees which cover the required subjects including, but not limited to food safety, handwashing, food handling, and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.	06/09/2024

South Dakota Department of Health

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	10595	A. BUILDING: ______ B. WING ______	04/25/2024

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S 301	Continued From page 3 to ensure all the required dietary training topics had been provided for two of two sampled dietary employees (H and U). Findings include: Review of the employee file and training records revealed: *Dietary aide (DA) H hired on 1/18/24 had not completed training on food serving and distribution procedures. *DA/cook U hired on 11/16/23 had not completed any of the required dietary training. Review of the dietary training packet revealed there was no training specific to serving and distribution procedures. Interview on 4/25/24 at 11:32 a.m. with administrator A revealed: *She was not aware of the specific dietary training requirements. Interview on 4/25/24 at 2:15 p.m. with dietary manager C revealed: *He was not aware that the required topic related to food serving and distribution procedures was not in the dietary training packet provided to new employees. *If it was not in the packet then they did not offer training on that topic.	S 301	Dietary Manager or designee will provide education to employees H and U to ensure completion of the required the required subjects including, but not limited to food safety, handwashing, food handling, and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. All other employees will be reeducated to ensure completion of the required dietary topics. Administrator or designee will audit employee files to ensure the required training occurs for all staff on payroll ~~weekly for 4 weeks and~~ monthly for ~~two~~ * months. * six BS Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	5/20/24