STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435073	A. BUILDING _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME OF ABERDEEN	1224 S HIGH ST ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 11/19/24 through 11/21/24. Bethesda Home of Aberdeen was found not in compliance with the following requirements: F656, F695, F812, and F849.	F 000		
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	F 656	MDS coordinator updated care plan for resident (288) to include type of O2, when to administer, flowrate, nebulizer treatments, monitoring of complications associated with use of O2, monitoring of SpO2 levels & vital signs as needed. MDS coordinator reviewed and updated as necessary all other resident's care plan with oxygen therapy. Frequency of cleaning changing of tubing's & humidifier bottle was added to the plan of care in the Treatment Administration Record (TAR) for resident 288. All other residents receiving oxygen therapy TAR's were found to be compliant. Resident 288's self-administration evaluation was correct; Nurse F was immediately educated on updated order for resident 288. No other residents at this time were identified. Resident 288 Hospice care plan was updated and integrated with the facility comprehensive care plan by MDS Coordinator. No other Hospice patients care plans were found not to be integrated.	1/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Eisenbeisz
TITLE: CEO/Administrator
(X6) DATE: 12/12/24

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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F 656	Continued From page 1 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 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 in collaboration with hospice a comprehensive care plan for one of one resident (288) who received oxygen and hospice services. Findings include: 1. Observation and interview on 11/19/24 at 9:42 a.m. with resident 288 in her room revealed: *She was short of breath, spoke softly, and was wearing oxygen nasal cannula tubing (tubing with nasal prongs) on her face. *There was an oxygen concentrator (a device that delivers concentrated oxygen) with a humidifier attached to it. The oxygen flow rate was set at 5 Liters (L) per minute. *A portable oxygen tank was on the back of her wheelchair. 2. Review of resident 288's electronic medical record (EMR) revealed:	F 656	The current Oxygen Administration policy included type of delivery system, when to administer, flow rates, monitoring SpO2 levels and/or vital sign as ordered, and monitoring complications associated with the use of oxygen was updated on 12/10/24 to include labeling and dating humidifier bottles and tubing with set up and weekly change. The facility added an Oxygen Concentration Policy on 12/10/24 which gives additional guidance on use and cleaning of oxygen concentrators. Education on proper execution of self-administration and staff administration of medication/treatments was provided immediately to Nurse F. Facility admission checklist updated for hospice admissions coming from home, to include update/new hospice plan of care. The admission check list has been updated to clean all equipment and change humidifier bottles, tubing, and nebulizer set up if brought into facility. Reeducation will be provided to all licensed nursing staff on the following policies oxygen administration, oxygen concentrator, nebulizer treatments, and bedside self-administration of medications by 12/27/24. Visual and documentation audits regarding Oxygen delivery system, cleaning of equipment, self-administration of medication and hospice integration of care plans from home, Oxygen delivery system, cleaning of equipment, and self-administration of medications audits will be conducted weekly for 1month, then monthly until QAPI committee decides to discontinue. Audits of integrated hospice care plans will be conducted when residents come from home on hospice. Audits will be conducted by the Director of Nursing (DON) or designee.	

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F 656	Continued From page 2 *Resident 288 had been admitted on 11/7/24 from home with continued hospice services. *Her diagnoses included "malignant neoplasm of unspecified bronchus or lung, chronic obstructive pulmonary disease, chronic kidney disease, and other forms of dyspnea." *There was a physician's order dated 11/7/24 for "O2 [oxygen] [with a flow rate of] 1 5L/N/C [liters via nasal cannula] every morning and at bedtime for comfort." 3. Interview on 11/21/24 at 8:40 a.m. with certified nursing assistant I revealed: *She confirmed that resident 288 was receiving hospice services. -She knew how to care for residents receiving hospice services because the nurse reviewed that information with her before each shift. *Her worksheet and the care plan in the provider's EMR also provided information about how much assistance a resident needed for transfers and personal care. *Hospice provided a bath to residents once a week. *She was unable to locate a hospice care plan for resident 288. 4. Review of resident 288's current care plan revealed: *Focus area: "SOB [short of breath] with resting, exertion and laying flat .... [Resident 288] was admitted on hospice from home." -Intervention: "O2 [oxygen] continuously." *Focus area: "Resident and family have opted for hospice benefits and comfort care only." -Intervention/Task: "Keep family and hospice involved in care planning and decision making as well as updated on any changes in conditions or orders."	F 656	DON will report monthly to the QAPI committee and quarterly to the Quality Assurance Committee with the Medical Director.	

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F 656	Continued From page 3 *The care plan did not include: -The type of oxygen delivery systems used by the resident included continuous oxygen via nasal cannula from an oxygen concentrator with a humidifier, nebulizer treatments, and a portable oxygen concentrator. -The frequency of cleaning and that equipment and changing the oxygen tubing and humidifier. -That resident 288 required assistance administering her nebulizer treatments. -Equipment settings for the prescribed flow rate. -Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered. -Monitoring for complications associated with the use of oxygen. -Goals integrated from an updated hospice plan of care when the resident moved from her private residence to the facility. -The services and equipment that hospice was providing to the resident. 5. Review of the hospice binder at the north nurse's station regarding resident 288 revealed: *It contained information about which nurse was assigned to resident 288 and instructions for when and how facility staff were to contact hospice. *The hospice plan of care was not located in that binder. *There was no documentation of the resident's oxygen needs or interventions in that binder. 6. Review of resident 288's paper "Hospice Plan of Care" provided upon request revealed: *It had not been uploaded into resident 288's electronic medical record. *"Location Type: Private Residence." *"Service Location" Home." *"Start of care date 09/22/2024."	F 656		

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F 656	Continued From page 4 -Resident 288 was admitted to the facility on 11/7/24. *"Oxygen; 1 ea [each] as directed; Instructions Use 2L/min [liters per minute] via nasal canula [cannula]." *"Oxygen; inhalation; gas; 1-5L as needed; Purpose: SOB." *"Goal #10: Patient/Caregiver will demonstrate progressive independence in the management of oxygen therapy as evidenced by appropriate adherence to ordered therapy and demonstration of appropriate safety measures by time of discharge." 7. Interview on 11/21/24 at 8:45 a.m. with director of nursing (DON) B revealed: *The services hospice provided to the residents varied from resident to resident based on their hospice diagnosis. -This information would have been found on the resident's care plan. *Minimum Data Set (MDS)/registered nurse (RN) K and infection control RN J were responsible for updating resident facility developed care plans "but any nurse can." -The care plan should have been updated "when there is any change" in the care that a resident received. *Hospice had a separate care plan that was part of the resident's overall care plan. -The hospice care plan was to be uploaded in their EMR system point click care (PCC) when it was completed. -She expected that the hospice care plan would have reflected the care resident 288 was receiving in the facility. -Resident 288's hospice care plan should have been updated when she moved from her private home to the facility.	F 656		

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F 656	Continued From page 5 *She confirmed that resident 288's care plan should have included: -Her oxygen needs which included: -The need for assistance completing her nebulizer and the use of the humidifier. --Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. -The amount of oxygen she received and the equipment she used. --Hospice provided resident 288 with an oxygen concentrator and she had her own portable oxygen tank. --Hospice provided the oxygen humidifier and nasal cannula tubing for the concentrator and for the portable, however, it was the responsibility of the facility nursing staff to change that oxygen tubing and humidifier. -The frequency of cleaning of the oxygen equipment and changing the oxygen tubing -Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. Review of the provider's 5/30/23 Oxygen Administration policy revealed: *"The resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as, but not limited to:" -"The type of oxygen delivery system." -"When to administer, such as continuous or intermittent and/or when to discontinue." -"Equipment setting for the prescribed flow rate." -"Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered." -"Monitoring for complications associated with the	F 656		

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F 656	Continued From page 6 use of oxygen." 8. Review of the provider's April 2019 Comprehensive Care Plan policy revealed: *"It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that include measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." *"The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS [Minimum Data Set] assessment."	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to maintain the cleanliness of the oxygen concentrator, tubing, and humidifier and to administer the nebulizer treatment appropriately after determining the resident could not self-administer that treatment for one of one observed sampled resident (288) who received oxygen. Findings	F 695	Resident 288 received all new oxygen and nebulizer tubing's and humidifier bottle. Her oxygen concentrator and portable concentrator were cleaned including filters. Weekly cleaning, changing tubing's and humidifier bottle was added to TAR. No other residents were identified at this time. Admission check list was updated for the RCC to make sure Batch oxygen and neb orders are in the TAR which includes the cleaning of equipment/filters, change tubing's and humidifiers. Education on proper execution of self-administration and staff administration of medication/treatments was provided immediately to Nurse F. Reeducation will be provided to all licensed nursing staff on the following policies oxygen administration, oxygen concentrator, nebulizer treatments and self-administration of medications by 12/27/24. Visual and documentation audits regarding the proper cleaning of oxygen and nebulizer equipment will be conducted weekly for 1month, then	1/5/25

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F 695	Continued From page 7 include: 1. Observation on 11/19/24 between 8:25 am and 9:02 a.m. with resident 288 in her room revealed: *At 8:25 a.m. registered nurse (RN) F started her nebulizer (neb) machine for the administration of her neb medication treatment and then left the room. -Resident 288 asked the surveyor to return when she completed that nebulizer treatment. *At 8:40 a.m. the nebulizer treatment was running and resident 288 was wearing a neb mask. *At 8:55 a.m. the nebulizer was still running and resident 288 was holding the mask in her hand. *At 9:02 a.m. RN F walked by resident 288's room and into room 509. Resident 288's nebulizer was still running at that time, and her neb mask was on the floor. Observation and interview on 11/19/24 at 9:42 a.m. with resident 288 in her room revealed: *Her breakfast tray was on the table. The individual containers were wrapped in plastic wrap and the fruit cup was unopened. She stated she could not open the fruit cup. "I'll just leave it." *She ate in her room by choice. *She was short of breath, spoke softly, and wore oxygen via a nasal cannula. *The oxygen concentrator was stored in the bathroom. -The oxygen concentrator was covered in white dust, and the filter on the back contained visible lint and debris. -The oxygen flow meter was set at five liters. -The oxygen tubing and the humidifier were not labeled or dated. -An oxygen humidifier container with a green top was attached between the concentrator and the tubing.	F 695	monthly until QAPI committee decides to discontinue. Audits will be conducted by the Director of Nursing (DON) or designee. DON will report monthly to the QAPI committee and quarterly to the Quality Assurance Committee with the Medical Director.	

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F 695	Continued From page 8 -The humidifier container was dry and contained an unidentified white flaky substance at the bottom. *There was a portable oxygen tank on the back of her wheelchair. -The nasal cannula connected to the portable oxygen was not labeled or dated. 2. Observation and interview with RN F in resident 288's room on 11/19/24 between 9:47 a.m. and 9:56 a.m. revealed: *The concentrator was stored in the bathroom because of the noise it produced and to provide more space in the room. *She stated the oxygen tubing and humidifiers were changed once a week on Wednesday as ordered on the treatment administration record (TAR). *When asked what was in the humidifier, she tapped the humidifier, and stated, "A smidge of water." *When asked to confirm that there was no water in the humidifier, she stated there was "dry water" in the bottom of the container, and stated "It's dirty," and that she would go get some "sterile water." *She stated that there should have been a sticker on the oxygen tube with the date it had been changed, but it "must have fallen off." *At 9:56 a.m. RN F returned to resident 288's room with an oxygen humidifier with a black top that contained "water," a nasal cannula, and green oxygen tubing. -She replaced the existing humidifier and tubing and dated it on a piece of tape. *She did not change the oxygen tube on the portable oxygen unit which hung on the back of the wheelchair. *There was no visible jug of distilled water in	F 695		

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F 695	Continued From page 9 resident 288's room or bathroom. 3. Interview on 11/19/24 at 10:15 a.m. RN F regarding resident 288's oxygen humidifier revealed: *When asked what had been in the humidifier which she had removed from resident 288's room she stated, "Dry water that has been dry for a day." *When asked where the oxygen humidifier brought to resident 288's room had been filled she took the surveyor to the unit kitchenette. *When asked again where the water had come from, she stated "The water jug was actually kept in the medication room." *When asked to see the jug, she stated it had been empty and thrown away and the trash had already been taken out. *The water jugs to fill the oxygen humidifiers came from the main kitchen. -She stated there were no more jugs of water on the unit and she would have to get more from the kitchen. *RN F stated she needed to pass medications and ended the interview. 4. Interview on 11/19/24 at 10:21 a.m. with RN C regarding oxygen equipment revealed: *Oxygen humidifiers were to be filled with distilled water. *She showed the surveyor a one-gallon jug stored in the unit's "utility room." *Each resident with an oxygen humidifier was expected to have a jug of distilled water in their room. -That jug would be dated on the day it was opened. *Open bottles of distilled water were not stored in the medication room or the kitchenette.	F 695		

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F 695	Continued From page 10 *She had not seen resident 288's humidifier and was unaware of where RN F would have filled her humidifier. *Hospice provided resident 288's concentrator, humidifier, and oxygen tubing. *The facility provided the distilled water, and the facility nurse changed the tubing every week on Wednesday, but not the humidifier. -She expected the nurse would have checked the humidifier and refilled it with distilled water "as needed." 5. Interview on 11/19/24 at 10:29 a.m. with RN L in resident 288's room revealed: *Hospice had provided resident 288 with the oxygen concentrator. *RN L confirmed that there was no jug of distilled water in resident 288's room. -She stated the distilled water would have been provided by the facility. *At 10:32 a.m. RN F entered the room, placed an unopened jug of distilled water, dated 11/19/24, on resident 288's bedside table, and then left the room. 6. Observation on 11/20/24 at 9:55 a.m. in resident 288's room revealed the nasal cannula attached to the portable oxygen on her wheelchair was resting on the floor. 7. Interview on 11/21/24 at 8:45 a.m. with director of nursing (DON) B revealed: *Hospice provided resident 288 with an oxygen concentrator and she had her own portable oxygen tank. *Hospice provided the oxygen humidifier and nasal cannula tubing for the concentrator and for the portable, however, it was the responsibility of the facility staff to change that oxygen tubing and	F 695		

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F 695	Continued From page 11	F 695		

humidifier.
*There was an order in the resident's treatment administration record (TAR) to change oxygen tubing once a week on Wednesdays.
-She expected that oxygen tubing would have been marked with the date they were changed on a small piece of tape.
*She expected the oxygen humidifier to have been filled by the nurse with distilled water provided by the facility whenever it was low and needed more water.
-Distilled water was kept in a one-gallon jug, with the date it was opened, in each resident's room who required it.
*She expected the nurse to clean the oxygen concentrator filter weekly when the tubing and humidifier were changed.
-The concentrator was to have been cleaned monthly.
*Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to.
-She expected that the nurse would have stayed with resident 288 while she completed her nebulizer treatment.

8. Interview on 11/21/24 at 9:35 am with infection control RN J revealed:
*There were hooks for oxygen tubing to hang on in each resident's room.
-She expected oxygen tubing, when not being used, to have been hung on those hooks.
*Oxygen humidifiers were filled with distilled water as needed.
-Each resident who required humidified oxygen would have had a dated one-gallon jug kept in their room.

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	435073	A. BUILDING _____ B. WING _____	11/21/2024

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BETHESDA HOME OF ABERDEEN	1224 S HIGH ST ABERDEEN, SD 57401

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F 695	Continued From page 12 9. Review of resident 288's electronic medical record (EMR) revealed: *Resident 288 had been admitted on 11/7/24 from home with continued hospice services. *Her diagnoses included "malignant neoplasm of unspecified bronchus or lung, chronic obstructive pulmonary disease, chronic kidney disease, and other forms of dyspnea." *Her Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated she was cognitively intact. *An 11/7/24 physician's order for "O2 [oxygen] 1-5L/N/C [liters via nasal cannula] every morning and at bedtime for comfort." *An 11/7/24 physician's order for "Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG [milligram]/3ML [milliliters]. 1 vial inhale orally four times a day." *An 11/7/24 physician's order for "Albuterol Sulfate Inhalation Nebulization Solution (2.5MG/3ML) 0.083%. 1 vial inhale orally via nebulizer every 4 hours as needed for SOB [shortness of breath]." *Her Medication Self-Administration Safety Screen completed on 11/13/24 revealed: -Medications being considered for resident self-administration included: --"Albuterol 0.083% q4hour [every four hours]." --"Ipratropium-Albuterol Inhalation .05-2.5mg/3ml." -"The resident can correctly administer inhalant medications according to proper procedure," was marked "Unable." -"It is reported that this resident is not capable of taking her neb [nebulizer] treatments unsupervised as before, weakness. Resident reports she falls asleep when she takes it and cant [can't] hold it. will switch to a mask." -"IDTC [interdisciplinary team] feels resident is	F 695		

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F 695	Continued From page 13 safe to administer listed medications?" was marked "No." *A physician's order to "Clean O2 concentrator with Clorox wipes, clean filters, change tubing. Every day shift every Wed [Wednesday] Clean O2 concentrator with Clorox wipes, clean filters with water and air dry, put new tubing on machine and date with tape. If they have a tank put new tubing on [the] tank." -This was marked as completed on 11/13/24. Review of the provider's 5/30/23 Oxygen Administration policy revealed: *"Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences." *"Cleaning of concentrators and filters will be completed weekly." *"Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated." *"Change humidifier bottle weakly Use only distilled water for humidification." *"Cleaning and care of equipment shall be in accordance with facility policies for such equipment." *"Staff shall monitor for complications associated with the use of oxygen intake precautions to prevent them .... Respiratory infections related to contaminated humidification systems."	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	The food temperature logs were moved immediately to a clipboard and placed on a hook next to the steam table. Policy was reviewed and updated by administrator A, culinary service manager D, culinary service manager E and registered dietitian. All chefs/ cooks will have in-service training on	1/5/25

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F 812	Continued From page 14 §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 safe food was at safe temperatures prior to serving residents food by one chef (H) during an observed breakfast meal service. Findings include: 1. Observation and interview on 11/19/24 at 7:45 a.m. with chef M, chef H, and culinary services manager (CSM) D revealed: *Chef M was at the steam table serving breakfast to residents and stated chef H would have done the food temperatures this morning. *Chef H was by the ovens and the food prep area, and stated she forgot to take the food temperatures that morning. -The food temperature logs indicated food temperatures had not been documented that morning and chef H stated she would sometimes take the food temperatures but not log them and sometimes she would just forget to take the food	F 812	proper taking and documentation of food temperatures and recording of food temperatures. Training occurred on 12/3/2024, with a make-up session occurring before 12/12/2024. Audits for proper temperature documentation started on 11/19/2024 and will occur weekly for four weeks, then monthly until QAPI determines sustained compliance. Audits will be conducted by the Director of Culinary services or designee. Director of Culinary services will report monthly to QAPI committee and administrator or designee to report quarterly to the QA&A committee with Medical Director.	

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F 812	Continued From page 15 temperatures. -She stated she should check the temperatures of the food coming out of oven and at the steam table. *CSM D told chef H to temp the next batch of food and log those temperatures. Chef H completed that task. 2. Record review and interview on 11/19/24 at 8:00 a.m. regarding food temperatures and documentation with CSM E revealed: *She stated she did not know the food temperatures (temps) had not been done that morning and that temps were not being documented on the logs. -She agreed the temperature logs indicated food temps had not been done as they should have been. -She stated she would check the logs periodically and had not been monitoring them for a while because the temps were being done, and said "I see now they aren't logging them again." *When asked how she would know food temperatures were at the appropriate temperature to safely serve food to residents without temping food before serving it to the residents, she stated, "I don't." *Food temperature logs were reviewed with CSM E and indicated multiple dates for breakfast, lunch, and supper did not have food temperatures documented. -There was no log sheet started for that week which indicated it should have been started on Sunday 11/17/24. -She expected that food would have been temped three times per day at each meal and documented on the logs. -She stated, "We will have to start monitoring the logs again."	F 812		

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F 812	Continued From page 16 *She stated she wasn't sure what the policy said and would have to look that up. 3. Observation on 11/19/24 at 11:11 a.m. revealed food temperatures were done for the lunch meal with no concerns and now placing temp log on wall beside steam table with logs from lunch and supper noted on the log. 4. Interview on 11/19/21 at 11:15 a.m. with chef G revealed, "Food temps should have been checked with each meal and logged." 5. Interview on 11/20/24 at 9:56 a.m. with chef M revealed he would have "temped" and logged two meals, twice for each meal, once for food removed from oven then again for food in the steam table during his shift. 6. Interview on 11/20/24 at 12:10 p.m. with administrator A revealed he was not aware that food temperatures were not taken or logged at meal times and expected that the residents' food would be temped with each meal. "We have come a long way in kitchen and dining, but temps should have been done." 7. Record review of food temperature logs from 10/19/24 to 11/19/24 revealed the residents' food for thirty 38 of 67 meals had not been temped or logged for breakfast, lunch, and supper. 8. Record review of the Provider's 2021 policy and procedure for food temperatures revealed, "the temperatures of all food items will be taken and properly recorded prior to service of each meal."	F 812		
F 849 SS=D	Hospice Services	F 849		

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F 849	Continued From page 17 CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the	F 849	MDS coordinator updated care plan for resident (288) to include type of O2, when to administer, flowrate, nebulizer treatments, monitoring of complications associated with use of O2, monitoring of SpO2 levels & vital signs as needed. Frequency of cleaning changing of tubing's & humidifier bottle was added to the plan of care in the Treatment Administration Record. MDS coordinator updated care plan for resident 288 to include identification of whether Hospice or facility is responsible for performing the respective functions that have been agreed upon. DON will meet with Hospice director by 12/18/24 to establish the process for hospice to develop a new facility-based initial care plan when an at home hospice resident is being admitted to SNF. These care plans will be kept in the facility hospice binder with the other hospice paperwork provided to facility. This will be utilized in addition to the facility baseline care plan & then integrated into the comprehensive care plan per the comprehensive care plan policy, which is utilized as part of the MDS, Care Area Assessment, and Care Plan development process. Once the comprehensive care plan is completed by facility staff the hospice initial care plan and plan of care will be pulled from the binder and scanned into the resident facility medical record. DON and ADON educated the MDS coordinators and Resident care coordinators on the integration of care plans between hospice and facility. Audits will be conducted by DON or designee when new hospice admissions occur. Audits will continue until QAPI committee decides to discontinue.	1/5/25

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F 849	Continued From page 18 LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies	F 849		

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F 849	Continued From page 19 determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the	F 849		

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F 849	Continued From page 20 provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial	F 849		

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F 849	Continued From page 21 well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the Hospice and Nursing Facility Services Agreement, the provider failed to ensure an integrated plan of care had been developed and made accessible between the provider's nursing staff and hospice agency for one of one sampled resident (288) who received hospice services. Findings include: 1. Review of resident 288's facility care plan revealed: *She had been admitted on 11/7/24. *Her diagnoses included "malignant neoplasm of unspecified bronchus or lung, chronic obstructive pulmonary disease, chronic kidney disease, and other forms of dyspnea." *[Resident 288] was admitted on hospice from home." *A focus area: "Resident and family have opted for hospice benefits and comfort care only." *A goal: "Will receive additional support from hospice. Have comfort and dignity maintained on [a] daily basis." *"Interventions/Tasks": -"Keep family and hospice involved in care planning and decision making as well as updated on any changes in conditions or orders." -"Keep hospice staff involved with changes and notify them in [the] event of death." -"Maintain [an] open line of communication and involvement with hospice staff." -"Offer emotional/spiritual support to [the] resident and family." Review of resident 288's paper "Hospice Plan of Care" provided upon request revealed:	F 849		

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F 849	Continued From page 22 *It had not been uploaded into resident 288's electronic medical record. *"Location Type: Private Residence." *"Service Location: Home." *"Principal Program: Home Hospice." *"Start of care date 09/22/2024." -Resident 288 was admitted to the facility on 11/7/24. Review of the hospice binder at the north nurse's station regarding resident 288 revealed: *It contained information about which nurse was assigned to resident 288 and instructions for when and how facility staff were to contact hospice. *The hospice plan of care was not located in that binder. *There was no documentation of the resident's oxygen needs or interventions in that binder. 2. Interview on 11/21/24 at 8:40 a.m. with certified nursing assistant I revealed: *She confirmed that resident 288 was receiving hospice services. -She knew how to care for residents receiving hospice services because the nurse reviewed that information with her before each shift. *Her worksheet and the care plan in point click care also provided information about how much assistance a resident needed for transfers and personal care. *Hospice provided a bath to residents once a week. *She was unable to locate a hospice care plan for resident 288. Interview on 11/21/24 at 8:45 a.m. with director of nursing (DON) B revealed: *The services hospice provided to the residents	F 849		

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F 849	Continued From page 23 varied from resident to resident based on their hospice diagnosis. -This information would have been found on the resident's care plan. *Minimum Data Set (MDS)/registered nurse (RN) K and infection control RN J were responsible for updating resident facility developed care plans "but any nurse can." -The care plan should have been updated "when there is any change" in the care that a resident received. *Hospice had a separate care plan that was part of the resident's overall care plan. -The hospice care plan was to be uploaded in their EMR system point click care (PCC) when it was completed. -She expected that the hospice care plan would have reflected the care resident 288 was receiving in the facility. -Resident 288's hospice care plan should have been updated when she moved from her private home to the facility. *She confirmed that resident 288's care plan should have included: -Her oxygen needs which included: -The need for assistance completing her nebulizer and the use of the humidifier. --Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. -The amount of oxygen she received and the equipment she used. --Hospice provided resident 288 with an oxygen concentrator and she had her own portable oxygen tank. --Hospice provided the oxygen humidifier and nasal cannula tubing for the concentrator and for the portable, however, it was the responsibility of	F 849		

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F 849	Continued From page 24 the facility nursing staff to change that oxygen tubing and humidifier. -The frequency of cleaning of the oxygen equipment and changing the oxygen tubing -Resident 288 had been able to self-administer her nebulizer treatments when she came into the facility, but it had been determined that she was no longer able to. 3. Review of the provider's 1/17/19 Hospice and Nursing Facility Services Agreement revealed: *"Facility's representative will perform the following duties: (a) Collaborate with Hospice staff and coordinate Facility staff's participation in the care planning process ..." *"Joint Responsibilities/Mutual and Hospice Promises. Development and Implementation of Plan of Care ....Hospice and Facility shall jointly develop and agree upon the Patient's plan of care ....Hospice and Facility each shall maintain a copy of each Patient's plan of care in the respective clinical records maintained by each Party." *"Hospice Plan of Care. All services provided to Hospice Patients under the Agreement must be in accordance with the plan of care." -"The plan of care shall identify the care and services needed and specifically identify whether Hospice or Facility is responsible for performing the respective functions that have been agreed upon and included in the plan of care." -"The plan of care shall reflect the participation of Hospice, Facility and the Hospice Patient and such Patient's family, to the extent possible including a description of the Hospice Services, Inpatient Services and Room and Board Services furnished by Facility."	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435073	A. BUILDING _____ B. WING _____	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME OF ABERDEEN	1224 S HIGH ST ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 on 11/19/24. Bethesda Home of Aberdeen was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Eisenbeisz
TITLE: CEO/Administrator
(X6) DATE: 12/12/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435073	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME OF ABERDEEN	**1224 S HIGH ST** **ABERDEEN, SD 57401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 11/19/24 for compliance with 42 CFR Part 483.90 (a)&(b) requirements for Long Term Care Facilities. Bethesda Home of Aberdeen was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Eisenbeisz
TITLE: CEO/Administrator
(X6) DATE: 12/12/24

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.

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
	10589	A. BUILDING: _____ B. WING _____	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME OF ABERDEEN	1224 S HIGH ST ABERDEEN, SD 57401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/19/24 through 11/21/24. Bethesda Home of Aberdeen was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 11/19/24 through 11/21/24. Bethesda Home of Aberdeen was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Eisenbeisz — TITLE: CEO/Administrator — (X6) DATE: 12/12/24