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
	435135	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT COUNTY HOSPITAL AND NURSING HOME	102 MAJOR ALLEN MARTIN, SD 57551

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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 4/25/22 through 4/27/22. Bennett County Hospital and Nursing Home was found not in compliance with the following requirements: F578, F657, F689, F700, F742, F758, F880, and F909. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/25/22 through 4/27/22. Areas surveyed included resident neglect. Bennett County Hospital and Nursing Home was found not in compliance with the following requirement: F742.	F 000	Submission of this Response and Plan of Correction (POC) is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute and should not be interpreted as an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the statement of deficiencies. Accordingly, the Facility has prepared and submitted this Plan of Correction for these deficiencies prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. Without waving the foregoing statement, the facility states that with respect to:	
F 578 SS=E	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.	F 578	SSD-G obtained signed resuscitation status for resident #12 from resident's POA on 05/13/2022. SSD- G obtained signed advanced directives for residents #1,2, and 26 from their Tribal legal guardian representatives on 05/13/2022. Resident #129 expired on 04/30/2022. Advanced directives for all other residents have been obtained from appropriate legal representatives, and/or for all cognitively capable residents per updated BIMS, by SSD-G. Hard copies of all signed forms have been placed in resident charts. SSD-G will be responsible for obtaining Advance Directives for all new admissions, to be signed by appropriate legal party or cognitively capable resident at time of admission. Facility Advance Directive Policy will be updated to address a resident's cognitive capability to complete their own advance directive by DON or designee. Care plan of resident 26 will be updated to reflect cognitive level by by 05/26/2022 by DON , or designee RN. All resident care plans will be updated to current Advance Directive status by 05/26/2022 by DON , or designee RN.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Michael Christensen :

TITLE
Chief Executive Officer

(X6) DATE
5/27/22

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 578	Continued From page 1 (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 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 observation, interview, record review, and policy review, the provider failed to ensure: *One of one sampled resident (12) cognitively incapable of determining their resuscitation code status had not signed their own advance directive. *Three of three sampled residents' (1, 2 and 26) legal guardians had identified and documented a resuscitation code status for them. *Two of four sampled residents (2 and 129) had their signed advance directive and physician order accurately documented in their medical records. Findings include: 1. Observation and interview on 4/26/22 at 9:46 a.m. with resident 12 revealed:	F 578	Facility staff will be educated/re-educated on advanced directives by the DON or designee by May 26, 2022. Advance Directive status will be checked Quarterly at the time of significant change in resident condition, or when other changes occur by the Interdisciplinary Team at scheduled MDS Care Plan meetings to insure accuracy of current wishes and matching of Care Plans to those wishes. SSD-G will monitor results for compliance monthly and report to QAPI Committee monthly for recommendations based on findings.	5/26/2022

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F 578	Continued From page 2 *He was sitting in his wheelchair watching TV. *He was able to follow simple conversation but unable to comprehend complex questions. Review of resident 12's medical record revealed: *He had a power of attorney (POA). *He was admitted on 11/1/16. *His 2/13/22 Brief Interview Mental Status score (BIMS) was 6, indicating severe cognitive impairment. *Diagnoses included cerebrovascular disease, dementia, expressive language disorder, and diabetes mellitus. *His medical record had a form titled To Limit The Scope of Emergency Medical Care. -It indicated he chose to have all medical procedures to sustain life. -It had been signed by him and witnessed by the provider's social services designee (SSD) G on 3/30/22. -This form was not signed by his POA. -His care plan indicated staff would initiate cardiac pulmonary resuscitation (CPR) if needed. 2. Review of residents 1 and 26s' care records revealed: *Advance directive forms had been signed by resident 1 on 3/30/22 and resident 26 on 11/9/20. -Both residents had been adjudicated incompetent and their legal guardians made decisions on their behalf. Interview on 4/26/22 at 2:30 p.m. SSD G regarding the above residents revealed: *She had spoken to the individual residents' guardians to validate their code status preferences for those residents. -Had not documented those conversations, but should have.	F 578		

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F 578	Continued From page 3 *It was unnecessary to have those residents sign advance directive forms since legal guardians had been appointed to make those decisions on their behalf. 4. Review of resident 2's medical record revealed: *She had a legal guardian. *On 1/17/22 her BIMS score was a 9, meaning her cognition was moderately impaired. *Her paper medical record had a form titled To Limit the Scope of Emergency Medical Care. -It had been signed by her and witnessed by the provider's SSD on 3/8/22. -It indicated she had chose not to be resuscitated. -This form had not been signed by her legal guardian. -Her care plan indicated staff would initiate CPR if needed. 5. Review of resident 129's medical record revealed: *He had a representative that made medical decisions for him. *His paper medical record had a form titled To Limit the Scope of Emergency Medical Care. -It indicated he was not to be resuscitated (DNR). -It had been signed by his representative and witnessed by the provider's SSD on 4/1/22. *His EMR did not have a code status included. *There was not a physician orders for code status. *His care plan had not included a code status. Interview on 4/27/22 at 9:51 a.m. with administrator A revealed: *He would have expected: -A form indicating preference of resuscitation being performed or not being performed to be signed by the resident, their representative, or	F 578		

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F 578	Continued From page 4 legal guardian. --A physician order to be obtained for this preference. -The preference to be recorded on the resident's care plan. *He was not aware the code status for resident's were not the same throughout their medical records. Review of the provider's August 2002 advance directive policy revealed: *"Policy: It is the policy of this facility to offer guidance and/or honor the request(s) of resident/patient through Advance Directives. This is based on the ethical principal of autonomy (a person's privilege of self-rule)." *"Procedure: -1. All patients who enter our facility must:" --"c. Have their advanced directives placed in their medical record." *That policy had not addressed a resident's cognitive capability to complete their own advance directive. Review of the provider's August 2002 care plan policy revealed: *"e...Advance Directives (If present) are addressed on the Care Plan."	F 578		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657	1.The care plans of residents 26, 16, 11, 22 and 128 have been updated to reflect behaviors, goals and interventions, accurate DNR status, and oxygen use as appropriate. Resident 129 expired on 4/30/22. 2.All resident care plans have the potential to be inaccurate. 3.All resident care plans will be updated. The care plans will be reviewed quarterly with every care team meeting, as needed at the time of significant change in resident condition, or when other changes occur to ensure care plan reflect current condition of residents.	

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F 657	Continued From page 5 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure 6 of 16 sampled residents (11, 16, 22, 26, 128, and 129) had their care plans updated and revised to reflect their status and care needs. Findings include: 1. Observations on 4/26/22 between 1:30 p.m. and 6:00 p.m., on 4/27/22 between 7:30 a.m. and 5:30 p.m., and on 4/28/22 between 8:00 a.m. and 3:00 p.m. of resident 26 revealed he: *Walked between his room and the dining room, the front of the nurses' station, and the weight scale next to the beauty shop throughout the day. *Did not initiate conversation, but would respond with "yeah" or "no" to questions asked of him. -Spoke unintelligibly with one particular	F 657	Facility staff will be educated/re-educated on comprehensive care plans by the DON or designee by May 26, 2022 4. Seven random care plans will be audited by the DON and/or designee weekly X 4 weeks, monthly X 4 months then quarterly X 1 with results taken to the QAPI committee by the DON or designee and continued until the facility demonstrates sustained compliance as determined by QAPI committee.	5/26/2022

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F 657	Continued From page 6 cognitively impaired resident. Review of resident 26's care record revealed: *Nurse progress notes and behavioral progress notes between 3/16/22 and 4/4/22 that indicated resident 26: -Had a history of exposing himself to staff and his peers. -Failed to recognize personal boundaries. -Required a private room due to his behaviors. -Was physically and verbally aggressive and confrontational towards staff and residents, threw objects within his reach, and had swung his arms towards others. Interview on 4/26/22 at 9:40 a.m. with certified nurse aide H regarding resident 26 revealed he sometimes threw things at others and yelled. Interview on 4/26/22 at 10:00 a.m. with social services designee (SSD) G regarding resident 26 revealed: *He had conflicts with specific residents. *She had noticed an increase in his pacing, yelling, and aggression towards staff in the past one to two months. Review of resident 26's revised 4/14/22 care plan revealed: *No mention of the history of behaviors described in the March 2022 behavior notes. *No mention of the behavioral incidents described in the April 2022 behavior note. *A goal to decrease the resident's tendency towards hoarding food in his room. 2. Review of resident 16's care record revealed: *A do not resuscitate (DNR) order signed by his provider on 3/30/22.	F 657		

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F 657	Continued From page 7 *Care plan dated 4/30/20 revealed the resident was a full code. *The signed DNR and care plan did not match with the residents preference. 3. Observation on 4/25/22 at 3:06 p.m. of resident 11 revealed he: *Had been sleeping in his bed. *Had an oxygen (O2) cannula placed in his nostrils. -This cannula was connected to an oxygen concentrator set at 2 liters per minute of oxygen flow. Observation on 4/26/22 at 8:06 a.m. of resident 11 revealed: *He had been in bed and was yelling, unintelligibly. Review of resident 11's medical record revealed: *A 2/3/22 brief interview of mental status (BIMS) assessment was still in progress and had not been completed. *A 2/9/22 Minimum Data Set Assessment indicated his cognition was severely impaired. *Certified nursing assistant (CNA) documentation showed he had been yelling 6 times from 4/7/22 through 4/20/22. *His Care plan did not: -Address his use of oxygen. -Address his cognitive impairment. -Have interventions for his yelling. *His physician orders included to change the O2 humidifier bottle and O2 tubing monthly; and to clean the O2 filter weekly. -They did not include orders for the administration of O2. Interview on 4/27/22 at 8:40 a.m. with CNA D regarding resident 11 revealed:	F 657		

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F 657	Continued From page 8 *He often yelled out when he was uncomfortable. *She knew this as the staff would reposition him and then he would stop yelling. 4. Observation on 04/26/22 at 10:21 a.m. of resident 22 revealed she *Had been sleeping in her bed. *Had an oxygen cannula placed in her nostrils. -This cannula was connected to an oxygen concentrator set at 2 liters per minute of oxygen flow. Review of resident 22's current care plan revealed it had not addressed her use of oxygen. 5. Review of resident 128's current care plan revealed no code status had been included. 6. Review of resident 129's current care plan revealed no code status had been included. Interview on 4/27/22 at 9:30 a.m. with quality improvement coordinator/registered nurse B revealed she: *Expected interdisciplinary team members to review and update individual care plans during quarterly care conference meetings. -It was the responsibility of every team member to update or revise individual care plans as changes occurred between care plan meetings. Interview on 4/27/22 at 9:51 a.m. administrator A regarding revealed his expectation would have been for: *Care plans to have included: -Current care being provided. -Advance directives. -The interdisciplinary team to update the care plan as needed.	F 657		

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F 657	Continued From page 9 *Care plan meetings to have included: -Discussion of current care being provided. -Review of advance directives. -A certified nursing assistants (CNA), as they would have direct knowledge of care required by residents and would be able to say if changes needed to be made to the care plan. Review of the provider's revised 8/2002 Care Plan policy revealed: *"Residents will receive and be provided the necessary care and services to attain or maintain the highest practical well-being in accordance with the comprehensive assessment. *Each resident will have an individualized comprehensive plan of care that includes the active and historical diagnosis, current physician orders, CNA POC {point of care} electronic flow sheet, Restorative flow sheet, 24 hour report sheet, EZ Graph, treatment sheet and PT/OT/ST {physical therapy, occupational therapy, speech therapy} if resident is receiving treatments, measurable objectives and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Through use of department assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs, and concerns, identified will be addressed." *"The care plan will emphasize the care and development of the whole person assuring that the resident will receive appropriate care and services." *"A qualified team of persons will review care plans at least QUARTERLY. Care plans will also be reviewed, evaluated, and updated when there is a significant change in the resident's condition	F 657		

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F 657	Continued From page 10 and/or in accordance with State guidelines. This plan of care will be modified to reflect the care currently required/provided for the resident." *"Procedure: -1. A Designated Staff Person Will: --a. Keep track of RAI (Resident Assessment Instrument) dates as well as care plan conference dates." --"d. Assure that care plans are updated and available within 3 days of the care plan conference." -"2. Care Plan Coordinator:" --"c. Function as the group leader during Care Planning, keeping the meeting on task, resident focused, and making certain that residents and their representatives have an opportunity to voice concerns." --"e. Function as the QA {Quality Assurance} Coordinator for the Care Plan by insuring that:" ---"All physician's orders are reviewed and reflects all diagnoses that are currently being treated." ---"Advanced Directives (if present) are addressed on the Care Plan." ---"The Care Plan reflects educational goals and approaches specific to the resident's needs, abilities, readiness, preferences, and length of stay." -"6. Reviews, reassessments, and Updates". --"b. Care Plans are to be reviewed at least quarterly and whenever there is any Significant change in the resident's condition and/or in accordance with State Guidelines."	F 657		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689	1. An updated smoking assessment has been completed on resident 8 and 23. Staff supervision and lighting of the cigarette by staff is required. Care plans are updated. 2. No other residents are at risk as no other residents are allowed to smoke.	

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F 689	Continued From page 11 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *Quarterly smoking assessments had been completed for the two of two residents (8 and 23) who smoked at the facility. *Care plan interventions to ensure the safety of one of two residents (8) who smoked had been followed. Findings include: 1. Observation and interview on 4/25/22 at 3:25 p.m. with residents 8 and 23 revealed they: *Received their cigarettes and a lighter from nursing staff then went outdoors to the back patio to smoke. -Resident 23 lit resident 8's cigarette. *Smoked at scheduled times sometimes on their own and sometimes together. *Had no staff supervision when they smoked. *They were the only two residents who smoked. Interview on 4/27/22 at 8:50 a.m. with resident 8 revealed he: *Confirmed burning the fingertips of a glove he used to wear for smoking. -Had not had any new accidents related to smoking. *Was not currently expected to use gloves or any other safety equipment when he smoked and did not require supervision to smoke. Review residents 8 and 23s' care records	F 689	Facility staff will be educated/re-educated on smoking policy by the DON or designee by May 26, 2022 3. Cigarettes and lighter for both smoking residents will be located at nurse's station. Staff will accompany residents and light the cigarette. Smoking assessments will be completed quarterly and care plans will be reviewed/updated quarterly at the care team meeting, and as needed at the time of significant change in resident condition or other changes to ensure care plan reflects current condition of the residents. 4. Activity Coordinator and/or designee will audit staff presence with the 2 smokers, ensuring the cigarette is lit by staff 5 X week for 4 weeks, monthly X 4 months, then quarterly X 1 with results taken to the QAPI committee by the DON or designee and continued until the facility demonstrates sustained compliance as determined by QAPI committee.	05/26/2022

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F 689	Continued From page 12 revealed: *Resident 8's most recent smoking assessment had been completed on 10/7/21. *Resident 23's most recent smoking assessment had been completed on 12/19/21. -There were no documented smoking accidents between 3/1/22 and 4/26/22. Review of resident 8 and 23s' care plans both revised on 2/21/22 revealed smoking assessments had been completed quarterly. 2. Review of resident 8's 10/7/21 smoking assessment revealed: *E. 7. Resident Need for Adaptive Equipment: -He required a smoking apron and one-on-one supervision when he smoked. *F. 2. Team (interdisciplinary team) Decision: -He was safe to smoke without supervision. *That assessment contained conflicting information regarding supervision required when he smoked and made no distinction between on grounds and off grounds smoking. Review of resident 8's care plan revised on 2/21/22 revealed: *Focus: -Refusal to wear protective gear when smoking off facility property. -A history (3/2/19) of burning the second and third finger of a glove when he smoked. *Goal: -Resident will not smoke without supervision. *Interventions: -"Reinforce the need for proper gear such as asbestos apron, coat, hat/cap, etc." -"He is to use a BBQ [barbeque] glove when he smokes" because he had refused to use a cigarette holder extender to prevent finger and	F 689		

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F 689	Continued From page 13 glove burning." Interview on 4/27/22 at 7:55 a.m. with registered nurse (RN) F revealed: *Resident 8 had not required adaptive equipment when he smoked and he smoked without supervison. -She had not known of any safety concerns when resident 8 smoked. Interview on 4/27/22 at 9:30 a.m. with quality improvement coordinator/RN B regarding the above information revealed: *Resident 8's most recent smoking assessment was not current and assessment recommendations contradicted his current smoking practices. *Smoking assessments for residents 8 and 23 were outdated and had not been completed quarterly as expected. -The results of those assessments should have been compared against the resident's care plan related to smoking and revised as needed to match, but that had not occurred. *The previous assistant director of nursing and the previous director of nursing (DON) had been responsible for completing those assessments. -A new DON was responsible now. Review of the 9/13/16 revised Smoking Regulations For Employees, Patients, Residents and Visitors policy revealed: *1. A smoking assessment was expected to be completed at admission if a resident smoked and quarterly assessments were expected to be completed thereafter. *6. "Staff or family member will accompany that person [resident] to the outside smoking area to light their cigarette for them. Staff member will be	F 689		

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F 689	Continued From page 14 present in the outside smoking area during designated smoking times when smokers are present." *"8. Residents MUST have on the provided smoking aprons at all smoking engagements. If the resident does not want to use the apron then the resident is not in compliance of the smoking policy and they will not be allowed to continue to smoke."	F 689		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure:	F 700	1. A bedrail safety assessment has been performed on residents 1, 8, 11, 12, 15, 16, 18, 22, and 26 Resident 129 passed away. For those residents or POAs requesting bedrails or for a medical condition or positioning assistance further risk analysis was performed utilizing the Bed Rail Risk Data Collection Tool. Informed consent demonstrating understanding of the risks and benefits has been signed by resident and/or POA. 2. All residents have the potential to be affected by not assessing bedrail safety. 3. All residents will have a bedrail safety assessment completed. Upon request of resident and/or POA for siderails or if medical condition or positioning assistance is needed, further risk assessment will be performed, including what symptoms will be managed by bedrails and what alternatives have been tried. A consent form understanding the risks and benefits will be signed by resident and/or POA. Care plan will be updated and reviewed quarterly at team care conference or as needed to reflect current condition of the resident. Facility staff will be educated/re-educated on bed rails by the DON or designee by May 26, 2022 by DON or designee 4. Six random resident beds will be audited for the presence of side rails and a corresponding completed side rail assessment, risk data review and signed consent by DON or designee weekly X 4 weeks, monthly X 4 months then quarterly X 1 with results taken to the QAPI committee by the DON or designee and continued until the facility demonstrates sustained compliance as determined by QAPI committee.	05/26/2022

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F 700	Continued From page 15 *Informed consent included education regarding the risks and benefits of side rails had been obtained from the resident or their representative and documented prior to side rail installation for ten of twelve sampled residents (1, 8, 11, 12, 15, 16, 18, 22, 26, and 129). *Side rail safety assessments had been completed and documented for ten of twelve sampled residents (1, 8, 11, 12, 15, 16, 18, 22, 26, and 129). Findings include: 1. Observations on 4/26/22 between 1:30 p.m. and 6:00 p.m. and on 4/27/22 between 7:30 a.m. and 11:00 a.m. of sampled resident rooms revealed residents 1, 8, 11, 12, 15, 16, 18, 22, 26 and 129 had quarter-length side rails on one or both sides of their beds. Review of care records for the residents identified above revealed: *No informed consent for side rail use had been documented prior to side rail installation. *No side rail safety assessments had been completed. Interview on 4/27/22 at 9:30 a.m. with quality improvement coordinator/registered nurse B revealed: *Side rail safety assessments had not been completed for the residents identified above. *It was her expectation: -The resident or their representative had been educated regarding the risks and benefits of side rail use by a nurse prior to side rail installation and documented informed consent was evident in the resident's care record. -Side rail assessments had been completed by the nursing staff at the time of side rail installation	F 700		

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F 700	Continued From page 16 and re-evaluated by the minimum data set (MDS) nurse no less than quarterly thereafter. *MDS nurse J was not available for an interview due to prior commitments. Review of the January 2019 revised Restraint policy revealed: *Procedure: -"4. The use of side rails as restraints is prohibited unless they are used to treat a resident's medical symptoms." -"1. Prior to restraint use the restraint assessment must be completed. A baseline restraint assessment will be completed by a licensed nurse. If restraints are deemed necessary, the restraint reassessment shall be completed quarterly or with a significant change in the resident's condition." -"6. j) If the resident is cognitively able he/she will be educated on the reason, type and risks/benefits should restraint usage become necessary." -"6. k) The resident's representative (sponsor) and/or family members will be promptly notified and educated about the type, reason, need and risks/benefits should the use of a restraint become necessary."	F 700		
F 742 SS=G	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or	F 742	1.Plan of Correction a. For the identification of lack of end dates on PRN anti-psychotropic drugs. b. The facility administrator, Director of Nursing (DON), and consultant pharmacist will review, revise, and create as necessary policies and procedures for the above identified area. c. All facility staff who prescribe, enter medication orders, or monitor drug therapy will be educated/re-educated by May 26, 2022 by pharmacist, DON or designee.	

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F 742	Continued From page 17 post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Identify, implement, and evaluate behavioral interventions and alternatives for caregivers to follow for one of one sampled resident (26) with mood and behavioral concerns. *Arrange for behavioral health follow-up for one of one sampled resident (26) with mood and behavioral concerns. Findings include: 1. Observations on 4/26/22 between 1:30 p.m. and 6:00 p.m., on 4/27/22 between 7:30 a.m. and 5:30 p.m., and on 4/28/22 between 8:00 a.m. and 3:00 p.m. of resident 26 revealed he: *Walked between his room and the dining room, the front of the nurses' station, and the weight scale next to the beauty shop throughout the day. *Did not initiate conversation, but would respond with "yeah" or "no" to questions asked of him. -Spoke unintelligibly with one particular cognitively impaired resident. Review of resident 26's medical record revealed: *His diagnoses included: degeneration of the nervous system due to alcohol, unspecified personality and behavioral disorder, stroke, anemia, and hyponatremia. *The March 2022 behavior notes had no behavioral incidents that month. -A 3/16/22 entry: "Resident has a hx [history] of exposing himself to staff and his peers. At times will attempt to masturbate in common areas.	F 742	d. for Resident 26 a full review of psychotropic medications was reviewed and ensured that no PRN order will extend beyond a 14-day period and a behavioral health follow up visit is scheduled with a behavioral health specialist. 2. Identification of Others a. ALL residents ordered PRN psychotropic drugs may be at risk. 3. System Change a. Facility staff who prescribe, enter medication orders, or monitor drug therapy will ensure anti-psychotropic medications are ordered with an end date of at most 14 days except as provided in 483.45 (e)(5) if the attending physician or prescribing practitioner believes that it is appropriate for the PRN psychotropic drug order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. b. Psychotropic Medication policy and procedure was updated. c. A psychotropic medication assessment will be completed per Psychotropic Medication Policy. d. A Psychotropic Medication tool will be added to the facility EMR to help provide visual cues to providers on psychotropic medication administration and orders. 4. Monitoring a. DON or their designee in conjunction with consultant pharmacist will conduct weekly auditing and monitoring to ensure no PRN order will extend beyond a 14-day period, that behaviors are being documented and a behavioral health follow up visit is scheduled with a behavioral health specialist. After 4 weeks of monitoring and compliance has been met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum of 2 months. Monitoring results will be reported by DON or their designee in conjunction with the consultant pharmacist to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the QAPI committee.	05/26/2022

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F 742	Continued From page 18 Resident fails to recognize personal boundaries as evidenced by taking personal belongings of other residents as well as staff including food/drink. Resident requires a private room due to hx of behaviors." *April 2022 behavior notes revealed documented behavioral incidents on 4/2/22, 4/4/22, 4/5/22, 4/11/22, and 4/24/22. *During the 4/4/22 incident he was physically and verbally aggressive and confrontational towards staff and residents, threw objects within his reach, and was swinging his arms towards others. -A medical provider arrived on-site, administered medication, and the resident was transferred to the emergency department (ED) for evaluation. *Changes were made to his medication regimen and a new order was written to arrange a behavioral health appointment following that ED visit. Review of resident 26's revised 4/14/22 care plan revealed: *No mention of any of the historical behaviors described in the March 2022 behavior notes. *No mention of the behavioral incidents described in the April 2022 behavior notes. *A goal to decrease the resident's tendency towards hoarding food in his room. Interview on 4/26/22 at 9:40 a.m. with certified nurse aide H regarding resident 26's behaviors revealed: *He sometimes threw things at others and yelled. -These episodes were sometimes unprovoked like "turning on a light switch." -Thought there were some staff who were able to redirect the resident during these episodes better than others.	F 742		

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F 742	Continued From page 19 Interview on 4/26/22 at 10:00 a.m. with social services designee (SSD) G regarding resident 26 revealed: *He had conflicts with specific residents. -Enjoyed unintelligible verbal exchanges with one cognitively impaired resident. *She had noticed an increase in his pacing, yelling, and aggression towards staff in the past one to two months. -Would try to shift his focus by asking "what's going on" when these incidents occurred. *She stated he received no known behavioral health services. Interview on 4/27/22 at 7:50 a.m. with registered nurse (RN) F regarding resident 26 revealed she: *Had acknowledged the medical provider's 4/4/22 order to arrange a behavioral health appointment. -Thought she told SSD G and expected her to make that appointment. *Knew the appointment had not yet been made and had not followed-up on that but should have. Interview on 4/27/22 at 1:45 p.m. with administrator A and quality improvement coordinator/RN B regarding resident 26 revealed they: *Were unaware the resident had no care plan that related to his behavioral history or his current behavioral status. *Confirmed the interdisciplinary team had not identified, documented, and evaluated possible causes for the increase in the resident's behavior. -Thought it may have been related to an adjustment in his anti-psychotic medication made in February 2022 or the death (a week prior to the 4/4/22 behavioral incident) of a resident he frequently sat with and "talked" to. --The possibility that resident 26 had been	F 742		

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F 742	Continued From page 20 negatively impacted by that had not been followed-up on but should have been. *Confirmed non-pharmacological interventions had not been developed for staff to follow when he demonstrated mood and behavioral concerns and there was no process to evaluate the success or failure of those interventions. *Would have expected RN F to arrange for behavioral health follow-up as ordered by the medical provider when she acknowledged that order. A Resident Mood and Behavior policy was requested of QIC/RN B on 4/27/22 at 8:45 a.m. On 4/27/22 at 10:30 a.m. QIC/RN B indicated the provider did not have a policy related to that. Refer to F758	F 742		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	F 758	1.Plan of Correction a. For resident 26, the facility will ensure that psychotropic drugs are not administered unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; resident 26 will receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; b. The facility Administrator, Director of Nursing (DON), and consultant pharmacist will review, revise, and create as necessary policies and procedures for the above identified area. c. All facility staff who prescribe, enter medication orders, or monitor drug therapy will be educated/re-educated by May 26, 2022 by Pharmacist, DON or designee.	

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F 758	Continued From page 21 specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure for one of one sampled resident (26) there was a specified duration of use identified for two of two as needed (PRN) psychotropic medication orders. Findings include: 1. Observations on 4/26/22 between 1:30 p.m.	F 758	e. for Resident 26 a full review of psychotropic medications was reviewed to ensure that no PRN psychotropic medication order will extend beyond a 14 day period. 2. Identification of Others a. ALL residents ordered PRN psychotropic drugs may be at risk. 3. System Change a. Facility staff who prescribe, enter medication orders, or monitor drug therapy will ensure anti-psychotropic medications for Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; and will ensure that all PRN orders for psychotropic drugs are ordered with an end date of at most 14 days except as provided in 483.45 (e)(5) if the attending physician or prescribing practitioner believes that it is appropriate for the PRN psychotropic drug order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. b. Psychotropic Medication policy and procedure was updated. c. A psychotropic medication assessment will be completed per Psychotropic Medication Policy. d. A Psychotropic Medication tool will be added to the Point Click Care EMR to help provide visual cues to providers on medication administration and orders. 4. Monitoring a. DON or designee in conjunction with consultant pharmacist will conduct auditing and monitoring weekly. After 4 weeks of monitoring and compliance has been met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum of 2 more months. Monitoring results will be reported by DON or their designee in conjunction with the consultant pharmacist to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the QAPI committee.	05/26/2022

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F 758	Continued From page 22 and 6:00 p.m., on 4/27/22 between 7:30 a.m. and 5:30 p.m., and on 4/28/22 between 8:00 a.m. and 3:00 p.m. of resident 26 revealed he: *Walked between his room and the dining room, the front of the nurses' station and the weight scale next to the beauty shop throughout the day. *Did not initiate conversation, but would respond with "yeah" or "no" to questions asked of him. -Spoke unintelligibly with one particular cognitively impaired resident. Review of resident 26's medical record revealed: *His diagnoses included: degeneration of the nervous system due to alcohol, unspecified personality and behavioral disorder, stroke, anemia, and hyponatremia. *On the morning of 4/4/22 he had an episode of physical and verbal aggression towards staff and residents that was prolonged and unable to be redirected. *A medical provider on-site at the time of that episode provided treatment and referred the resident to the emergency department (ED) for further evaluation. -He returned to the facility later that same morning. *New medication orders upon return from the ED included: -One milligram Ativan by mouth every 4 hours PRN. -One milligram Ativan solution intramuscularly every 4 hours PRN. -There were no end dates for those prescribed PRN psychotropic medications. Review of resident 26's 4/4/22 through 4/26/22 medication administration record (MAR) documentation revealed: *Two active orders for PRN Ativan.	F 758		

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	435135	A. BUILDING _____ B. WING _____	C 04/27/2022

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F 758	Continued From page 23 *Oral PRN Ativan had been administered on twelve different days since it had been started. -It was administered twice on one of those twelve days. *He had not received intra-muscular Ativan during that time. Interview on 4/27/22 at 7:50 a.m. with registered nurse F regarding resident 26 revealed: *His most recent PRN Ativan administration was 4/24/22. *Stated PRN psychotropic medication orders were supposed to have an end date no later than fourteen days from their start date. -It had been longer than fourteen days since those Ativan orders had been started. *She had not contacted the resident's medical provider to discuss the PRN Ativan orders, but should have. Review of the revised September 2002 Medication: Psychoactive policy revealed: *Procedures for the use of non-emergency and emergency administration of psychoactive medication, and new admissions already receiving a psychoactive medication. -No procedure for the use of PRN administration of psychoactive medication. Refer to F742.	F 758		
F 880 SS=E	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	F 880	1.For the identification of lack of: *Appropriate hand hygiene and glove use during cares that included obtaining blood glucose level, tube feeding procedure, and wound care. *Appropriate procedural technique for maintenance of wound care supplies during care.	

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F 880	Continued From page 24 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, 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.	F 880	The administrator, DON, and/or designee in consultation with the medical director will review, revise, and create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services, including LPN -C, will be educated/re-educated by 05/26/2022 by the DON, Infection Preventionist or Designee. 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate hand hygiene and glove uses during identified cares. *Appropriate procedural technique during wound care. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 05/26/2022 by the DON, Infection Preventionist or Designee. 3. Root cause analysis was conducted on 05/12/2022 using an Ishikawa Diagram tool and answering the 5 Whys: We discovered that there was insufficient traveling nurse orientation to our process, that the wound cart was not being utilized as intended, that barrier sheets and handwashing liquids were not readily available and that we were not adequately providing Infection Control nurse time and resources for proper oversight, training time or auditing time. Administrator, DON, medical director, Infection Preventionist, Infection Control Nurse and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator and infection control team members contacted the Great Plains Quality Improvement Network (QIN) and spoke with two quality improvement advisors on 05/18/2022 and reviewed both the five why's tool findings and the Ishikawa Diagram tool information and details including	

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F 880	Continued From page 25 (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. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure proper infection prevention and control practices were maintained by one of one licensed practical nurse (LPN) (C) for: *Proper hand hygiene and glove use during: -A procedure to obtain a resident's blood glucose level for one of one resident (5). -A tube feeding procedure for one of one sampled resident (11). -Wound care for one of one sampled resident (129). *Placement of a barrier between wound care supplies and bedside table and resident bed during wound care for one of one sampled resident (129). Findings include:	F 880	findings related to measurement, materials, methods (P&P), Environment, machines /equipment /and systems as well as People and the contribution of each component to the overall root cause of infection control issues. Solutions included hiring an additional RN to provide additional resources for Infection control management and training. An Infection Control BSN was hired on 05/18/2022. 4.Administrator, DON, and/or designee will conduct auditing and monitoring 2 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches is to ensure effective implementation and ongoing sustained change. *Staff compliance in the above identified area. *Other areas as identified through the Root Cause Analysis exercise and process. After 4 weeks of monitoring, demonstrating that these expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 additional months. Monitoring results will be reported by administrator, DON, and/or a designee to the Infection Control Committee and to the QAPI committee and will be continued until the facility demonstrates sustained compliance as determined by QAPI committee.	05/26/2022

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F 880	Continued From page 26 1. Observation on 4/26/22 at 8:02 a.m. with LPN C during a blood glucose monitoring procedure for resident 5 revealed she: *Performed a fingerstick blood glucose procedure. *Removed the disposable glove she had been wearing, but did not perform hand hygiene. *Put on a pair of disposable gloves. *Wiped the glucose monitor with the disinfecting wipes. *Removed the disposable gloves, but did not perform hand hygiene. 2. Observation on 4/26/22 at 11:45 with LPN C during resident 11's tube feeding procedure revealed she: *Obtained a disposable barrier from the medication cart, and placed it on the bedside table. *Shook a container of tube feeding formula. *Removed the plastic lid from the formula. *Put on a pair of disposable gloves, without performing hand hygiene. *With these gloves she: -Poured the formula into a plastic container. -Poured water into a different plastic container. -Touched her stethoscope that was hanging around her neck. -Obtained a clean dry wash cloth from the bathroom, and placed it on the resident's lap. -Closed the divider curtain in the room. -Placed a tube feeding syringe on the clean dry cloth. -Completed the tube feeding procedure. -Rinsed out the plastic container and syringe. -Placed the containers and syringe on a wash cloth lying on the bedside stand. -Put the syringe plunger back into place and	F 880		

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F 880	Continued From page 27 placed the syringe in a plastic bag which she left open. *Removed her gloves and washed her hands. 3. Observation on 4/26/22 at 10:15 a.m. of LPN C preparing for and performing wound care with resident 129 revealed: *Without performing hand hygiene, she gathered extra pairs of gloves, a container with a tube of zinc ointment inside, and a handful of gauze pads and laid them directly on top of an uncleaned bedside stand then put on a pair of gloves. *Without placing a clean barrier down first she moved those supplies directly on top of the resident's bed, removed his soiled Optifoam dressing from his buttock, and laid that on his bed. *Without removing her soiled gloves, she sprayed cleanser on his buttock and used some of the gauze pads laying on his bed to wipe his skin. *She removed her gloves and without performing hand hygiene put on a clean pair of gloves. -Squeezed some of the zinc ointment directly onto the fingertip of her glove and applied it to the resident's buttock then put a clean Optifoam dressing on it. *Without changing her gloves, she wiped the resident's peri-area with a cleansing cloth, removed her gloves, washed her hands, and applied new gloves. -Removed the Optifoam dressing from the back of his left calf, sprayed skin cleanser on that area, and wiped it with the remaining gauze pads on his bed. *Without changing her gloves, she removed adhesive from a clean Optifoam bandage and applied that bandage to the resident's calf. Interview on 4/26/22 at 11:00 a.m. with LPN C	F 880		

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F 880	Continued From page 28 regarding the above wound care revealed she: *Agreed with the above observations. *Should have placed her wound care supplies on clean surfaces or a clean barrier instead of the bedside stand and on top of the resident's bed. *Had missed more than one opportunity for hand hygiene and glove change in between touching clean and unclean areas of the resident's body and clean and unclean wound care supplies. Interview on 4/2722 at 9:45 a.m. with quality improvement coordinator/registered nurse C regarding the above wound care observation revealed: infection prevention and control practices including appropriate hand hygiene, glove use, and handling of wound care supplies had not been followed by LPN C, but should have been. Review of the provider's revised February 2022 Handwashing & Use of Personal Protective Equipment (Gowns, Gloves, Mask, Goggles) policy revealed: *"Policy Statement: This policy covers handwashing and the use of Personal Protective Equipment (PPE). Universal Precautions are based on the assumption that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membranes potentially contain infectious agents that may be transmitted during healthcare delivery. Excellent hand hygiene and use of PPE are included in a group of infection prevention practices that apply to all patients, in any setting. These precautions are also intended to protect patients by ensuring that healthcare personnel do not carry infectious agents to patients on their hands or on equipment used during patient care." *"Policy Guideline:"	F 880		

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F 880	Continued From page 29 -A. Handwashing" --"4. If hands are not visibly soiled, the [referred method of hand decontamination is with an alcohol-based hand rub." ---"f. After removing gloves/between glove changes." -"B. Gloves" --"3. Remove gloves after contact with a patient and/or the surrounding environment using proper technique to prevent hand contamination." --"6. Change gloves during patient care if the hands will move from a contaminated body-site to a clean body site. Remember to wash hands between glove changes."	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 ralls 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, and policy review, the provider failed to assess side rails on 10 of twelve sampled residents' beds (1, 8, 11, 12, 15, 16, 18, 22, 26, and 129) routinely as a part of a preventative maintenance program to ensure those side rails were in good working order and safe from possible resident entrapment. Findings include: 1. Observations on 4/26/22 between 1:30 p.m. and 6:00 p.m. and on 4/27/22 between 7:30 a.m.	F 909	Maintenance staff will conduct regular quarterly inspections of all bed frames, mattresses and bed rails as part of regular maintenance to identify areas of possible entrapment. Bed rails will only be utilized and implemented by direction of Director of Nursing per Nursing assessment findings. The maintenance staff have inspected bed frames, mattresses and bed rails on residents 1,8,11,12,15,16,18,22,26 &129, and will continue to inspect as part of a regular maintenance program to ensure bed frames, mattresses and bed rails are in good working order and safe from possible resident entrapment or injury. The maintenance staff will inspect bed frames, mattresses and bed rails on all resident beds to ensure they are safe from resident entrapment or injury. Preventative bed maintenance policy was developed by Maintenance manager and will be presented 5/19/2022 at scheduled QAPI Meeting. The administrator, maintenance manager, and/or designee in consultation with the DON will review, revise, and create as necessary policies and procedures, and tracking forms for the above identified areas	

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F 909	Continued From page 30 and 11:00 a.m. of sampled resident rooms revealed residents 1, 8, 11, 12, 15, 16, 18, 22, 26, and 129 had quarter-length side rails on one or both sides of their beds. Interview on 4/26/22 at 3:39 p.m. with maintenance director E regarding routine side rail maintenance revealed: *It was the responsibility of caregivers to identify and inform him of any bedrail safety concerns. -The maintenance department staff addressed those concerns. Interview on 4/27/22 at 9:30 a.m. with quality improvement coordinator/registered nurse B revealed she: *Expected side rails were routinely inspected for safety. *Thought the director of nursing and/or the assistant director of nursing was for responsible for ensuring those assessments had been completed. Interview on 4/27/22 at 1:20 p.m. with administrator A revealed: *The maintenance department was responsible for conducting and documenting routine safety inspections of side rails. -He had not known those assessments were not occurring. *He expected side rails had been inspected at the time they were installed, no less than quarterly, and as needed to ensure those rails were compatible with the bed frame, in good working order, and safe from possible resident entrapment. Review of the March 2015 revised Bedside Rails policy and the January 2019 Restraint policy	F 909	Maintenance manager, or designee, will audit all beds quarterly for maintenance/safety as stated above and report monthly to QAPI Committee. Changes to monitoring schedule will take place when needed per findings and QAPI Committee recommendations	05/26/2022

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F 909	Continued From page 31 revealed no mention of a preventative maintenance program for side rail use.	F 909		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 4/25/22 through 4/27/22. Bennett County Hospital and Nursing Home was found in compliance.	E 000		

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

Michael Christensen

TITLE: Chief Executive Officer

(X6) DATE: 05/21/2022

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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	435135	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/26/2022**

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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 4/26/22. Bennett County Hospital and Nursing Home 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: Michael Christensen

TITLE: Chief Executive officer

(X8) DATE: 05/21/2022

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

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement Surveyor: 43844 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/25/22 through 4/27/22. Bennett County Hospital and Nursing Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 43844 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 4/25/22 through 4/27/22. Bennett County Hospital and Nursing Home was found in compliance.	S 000		

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

Michael Christensen | Chief Executive Officer | 05/21/2022