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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/25/22 through 4/27/22. Bethany Home Sioux Falls was found not in compliance with the following requirements: F657 and F880.	F 000		
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-- (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	F 657	On 5/20/2022, the DON and IDT assessed the resident and reviewed and updated the comprehensive care plan to reflect resident's current status for resident 14 including history of hospitalization with potential for recurring Pneumonia. On 5/20/2022, the DON and IDT, in collaboration with the dietician, assessed the resident and reviewed and updated the comprehensive care plan to reflect resident's current status for resident 27 inclusive of nutritional status and antipsychotic drug use and side effect monitoring. On 5/20/2022, the DON and IDT assessed the resident and reviewed and updated the comprehensive care plan to reflect resident's current status for resident 28 inclusive of interventions to prevent falls. On 5/20/2022, the DON and IDT in collaboration with hospice, assessed the resident and reviewed and updated the comprehensive care plan to reflect resident's current status for resident 6 inclusive of Hospice and ADL needs. On 5/18/2022, the MDS coordinator in collaboration with the DON reviewed and revised the Care Plan Policy to reflect significant changes that may prompt a care plan review required by IDT; daily process methods to assist with keeping care plan current; and that all long-term care residents returning from a hospital stay will have a full care plan review done by the IDT within 72 hours.	6/16/2022

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

Deborah Herrboldt | Administrator | 05/19/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 1 by: Based on observation, interview, and record review, the provider failed to ensure care plans were revised and updated to reflect the resident's current needs for 4 of 12 sampled residents (6, 14, 27, and 28). Findings include: 1. Record review for resident 14 revealed: *She had been admitted to the hospital on 4/2/22 for pneumonia. -She had received intravenous antibiotics in the hospital and had three days of oral antibiotics upon her return to the nursing home. *The pneumonia diagnosis and antibiotics had not been listed on the resident's comprehensive care plan. *No other interventions related to pneumonia had been documented on her care plan. Interview on 4/27/22 at 9:50 a.m. with director of nursing (DON) C and licensed practical nurse (LPN), manager/environmental services E, revealed: *It was their expectation that resident 14's care plan would have been updated upon her return from the hospital to reflect her diagnosis of pneumonia and order for antibiotics. 2. Review of resident 27's weight record revealed: *On 3/23/22, she had weighed 112.2 pounds (lbs). *On 4/22/22, the resident weighed 123.4 lbs, which had been a 9.98 percent gain. Review of registered dietician J's 4/23/22 progress note indicated "weight gain is desirable for this resident." -Resident 27 had a history of weight loss.	F 657	On 5/16/2022, the Administrator and DON created the Hospice Program Policy which details expectations regarding the responsibilities of hospice and the facility in meeting the needs of the resident including coordination of the care plan. On 5/18/2022, the MDS coordinator in collaboration with the DON created the Resident Assessment Instrument Policy. On 5/18/2022, the MDS Coordinator in collaboration with the DON reviewed and revised the Fall Prevention Policy to assure IDT fall prevention recommendations are included in the resident's comprehensive care plan. On 5/18/2022, the DON reviewed and revised the Checklist for Falls Procedure to include care plan intervention updates. On 5/18/2022, the DON reviewed the Hospice Care Plan Policy and found it to be correct. On 5/27/2022, the MDS Coordinator will provide personal inservice education on the revised Care Plan Policy, Hospice Care Plan Policy, Hospice Program Policy, Resident Assessment Instrument Policy, Fall Prevention Policy, and the Checklist for Falls Procedure to LPN E with competency testing. On 5/20/2022, the DON will provide personal inservice education on the revised Care Plan Policy, Hospice Care Plan Policy, and Hospice Program Policy to CNA I with competency testing.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2 *Review of resident 27's medical record and physician's orders dated 3/23/22, 3/35/22, and 4/14/22 revealed: *Her diagnoses had included: -Unspecified dementia with behavioral disturbance, dementia in diseases classified elsewhere, Alzheimer's disease, and chronic kidney disease, stage 3. *She had been admitted from a local hospital on 3/23/22, taking Seroquel 12.5 mg in the evening. *The Seroquel dosage had been increased twice since her admission, on 3/25/22 and 4/14/22. Review of resident 27's care plan revealed: *It had not included a nutrition plan/goals/interventions. *It had not mentioned the use of antipsychotic medications or monitoring for side effects related to antipsychotics. Interview on 4/27/22 at 4:05 p.m. with DON C regarding resident 27's care plan for nutrition and antipsychotic use and side effect monitoring revealed: *Her expectations would be that her nutrition plan/goals/interventions and the use of antipsychotic medication and side effect monitoring would have been included on her care plan. *Further discussion and record review with DON C revealed that resident 27 had been on Seroquel 12.5 mg daily prior to her hospitalization. 3. Interview on 4/25/22 at 4:41 p.m. with resident 28 in his room, when he had been lying on his bed revealed he said he had a fall a couple weeks ago, "I didn't get hurt. "I've had a few falls." Record review from 3/1/22 to 4/25/22 for resident	F 657	Beginning 5/24/2022, the DON or her designee will provide training to all nursing staff and members of the interdisciplinary team on the revised Care Plan Policy, Hospice Care Plan Policy, Hospice Program Policy, Resident Assessment Instrument Policy, Fall Prevention Policy, and the Checklist for Falls Procedure with competency testing. Bethany Home Sioux Falls considers care planning to be of the upmost importance. Therefore, beginning 5/20/2022 all resident care plans will be reviewed by the interdisciplinary team to ensure that they are reflective of the resident's current conditions, needs, and desires. All revisions will be completed by 6/16/2022. Beginning 6/16/2022, the DON or her designee will complete a weekly audit of all falls to ensure that interventions have been transcribed to the care plan. The DON or her designee will report findings to the quarterly QAPI committee and continue audits for as long as the committee deems necessary. Beginning 6/16/2022, the DON or her designee will audit 4 random care plans weekly to ensure all care plans are correct and properly reflect the resident's current conditions and preferences. The DON or her designee will present the findings of the audits to the quarterly QAPI committee for as long as the committee deems necessary. Beginning on 6/16/2022, the MDS Coordinator or her designee will be auditing the monthly care plan completion schedule on a weekly basis to ensure completion of comprehensive care plans as scheduled. The MDS Coordinator or her designee will present the findings of the audits to the quarterly QAPI committee for as long as the committee deems necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3 28 revealed: * He has had two falls in the past two months, on 3/14/22 and 4/18/22. *He had not received any injuries from either fall. *Both falls had been related to self-transferring in his room. *His care plan interventions had not been updated following the falls on 3/14/22 and 4/18/22. *The only thing that had been added to his care plan was the date of the fall, where he had been found, and that he had received no injuries. Review of the provider's Checklist for Falls or Incidents form revealed comments on the report that could have been added to resident 28's care plan, included: *"Res [resident] reminded to call for help when needed. *Staff make sure wheelchair is close enough to bed. *Spoke with resident about using call light. *Staff aware to make sure w/c [wheelchair] is close to bed. Resident does self-transfer from bed to w/c independently at baseline." Interview on 4/27/22 at 4:40 p.m. with DON C revealed: *"IDT [inter-disciplinary team] huddles are completed at time of fall with staff on the unit. *If new interventions are identified such as a fall mat, low bed, positioning devices; they are put in place at that time. *Resident's primary care provider and family are notified of fall and new interventions if needed." 4. Observation of resident 6 on 4/26/22 at 10:10 a.m. revealed the resident was awake in her room sitting in her recliner. The resident did not	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4	F 657		

respond when this writer knocked on the room door and greeted her, but she did move her gaze towards the room door.

Interview on 4/26/22 at 10:18 a.m. with certified nursing assistant (CNA) I regarding resident 6 revealed:
*The resident was not able to walk or talk.
*Staff tried to toilet the resident, and she wore an incontinent brief.
*She was not sure if resident 6 was on hospice care.
-During the conversation, CNA I walked down the hallway to ask another unidentified staff member if the resident was on hospice and returned to confirm she was on hospice care.

Review of resident 6's medical record revealed:
*She was admitted on 11/9/21 on hospice care.
*Her diagnoses included dementia, depression, and diabetes.

Review of resident 6's 11/9/21 "Initial Plan of Care" revealed she:
*Was "non-ambulatory," used a mechanical stand lift with the assistance of two staff and a wheelchair.
*Needed assistance with all of her activities of daily livings (ADLs).

Review of resident 6's 11/16/21 admission Minimum Data Set (MDS) assessment revealed she:
*Required staff assistance with all ADLs.
*Was always incontinent and required extensive assistance with using the toilet.
*Was on hospice care.

Review of resident 6's current care plan, printed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 5 on 4/26/22, revealed it did not address: *Her needed assistance with ADLs which included the level of assistance needed and what interventions were to be used. *Her need for extensive assistance with toileting and what interventions were to be used. *Her hospice care, including what services the hospice agency would provide. Interview on 4/27/22 at 1:49 p.m. with DON C regarding the hospice plan of care revealed: *She expected the hospice plan of care should be available. *The hospice agency provided a "green sheet" detailing how often the hospice nurse and CNAs would come to the provider and what services they would provide. *She could not find either the hospice plan of care or the "green sheet." Interview on 4/27/22 at 3:12 p.m. with MDS coordinator/infection control D regarding hospice care services revealed she: *Stated hospice care was hard to care plan as it changed frequently. *Stated for resident 6, the hospice agency provided the following: -A hospice nurse once a week. -A hospice CNA three times a week. -Other services included a chaplain and a bereavement coordinator. *Confirmed resident 6's care plan had not included the hospice services provided by the hospice agency's nurse, CNA, chaplain, and bereavement coordinator. Review of the provider's 3/15/22 Hospice Plan of Care policy revealed: *The provider "will ensure that each Hospice	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 patient's written Plan of Care includes both the most recent hospice plan of care which will reflect: -Hospice patient and family goals and interventions based on the problems identified by the Hospice patient assessments. -Participation and services provided by hospice..." *"Specifically, the Hospice Plan of Care includes: -Identification of Hospice services ..." -"Detailed statement of the scope and frequency of Hospice services." *"Hospice and [provider name] will jointly develop and agree upon a coordinated Plan of Care..." *"The Plan of Care will identify which provider is responsible for performing the respective functions that have been agreed upon and included in the Plan of Care."	F 657		
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 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	F 880	On 4/27/2022, LPN E instructed LPN F and CNA G to immediately stop storing gloves in their pockets and checked all other staff to ensure no glove storage in their pockets and found no further violations of improper glove storage. On 5/16/2022, the Administrator and Assistant Administrator contacted the South Dakota Quality Improvement Organization and discussed the infection control deficient findings. The QIO representative shared resources to assist with the root cause analysis, infection control training materials, and other guidance to assist with achievement of staff compliance.	5/26/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880	On 5/16/2022, the DON, Administrator, Assistant Administrator, and direct care staff collaborated on the 5 Whys regarding glove storage in pockets. The team determined that gloves had not been properly stocked in resident rooms, specialty gloves were not readily available, and direct care staff did not know this was improper storage due to it not being included in the Personal Protective Equipment- Glove Use Policy. The team agreed that in addition to the education and training already noted in the plan of correction, a system change strategy to add stocking of gloves during linen pass to the CNA task list will be implemented beginning on 5/18/2022. Beginning on 5/18/2022, stocking specialty gloves in every resident room will also be added to the CNA task list as an additional system change strategy. On 5/16/2022, the DON, Administrator, Assistant Administrator, and direct care staff collaborated on the 5 Whys regarding disinfecting of mechanical lifts, hand hygiene, and improper glove use. The team determined a root cause of lack of compliance with previously provided training and education, lack of constant supervision, lack of personal and peer to peer accountability, and lack of awareness of the potential severity of the risk of infection by failure to follow policies and procedures. In addition to the training and education provided in this plan of correction, beginning on 5/18/2022, the DON or her designee will implement a system change strategy to foster peer to peer accountability through the use of a code word to alert staff to stop and correct to ensure their compliance with infection control procedures. On 5/16/2022, the Administrator and DON, in consultation with the Medical Director, reviewed the Personal Protective Equipment- Glove Use Policy and revised it to include gloves are to be stored in their original box container or other Bethany approved glove dispenser. Gloves are never to be kept in employee's pocket. On 5/16/2022, the DON and Administrator, in consultation with the Medical Director reviewed and revised the Infection Control Guidelines for all Nursing Procedures Policy to include proper storage of gloves.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 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 infection control practices were followed for: *One of one licensed practical nurse (LPN) F using gloves that had been stored in her shirt pocket during medication pass. *One of one certified nursing assistant (CNA) G using gloves that had been stored in her pocket. *Cleaning of a mechanical lift after use for two of two observations by CNA H. Findings include: 1. Observation on 4/27/22 from 7:17 a.m. through 7:45 a.m. of LPN F while passing medications revealed she had put on gloves that had been in her shirt pocket three times. Interview on 4/27/22 at 7:45 a.m. with LPN F revealed: *Her pockets were not clean. *She should not keep clean gloves in her pockets. Interview on 4/27/22 at 7:55 a.m. with LPN nurse manager/environmental services E revealed: *Staff should not have stored gloves in their pockets. *Staff had been educated that once gloves were in their pockets they were contaminated.	F 880	On 5/16/2022, the Administrator and DON, in consultation with the Medical Director, reviewed the Hand Washing/Hand Hygiene policy and found it to be correct. On 5/17/2022, the Administrator and DON, in consultation with the Medical Director, reviewed the Standard Precautions Policy and found it to be correct. On 5/18/2022, the DON provided personal in-service education on the Personal Protective Equipment-Glove Use Policy, Hand Washing/Hand Hygiene Policy, and Standard Precautions Policy to LPN F with return demonstration. On 5/18/2022, the DON provided personal in-service education with LPN F on the video simulation training on infection control practices titled "Create a Culture of Safety with Partnering to Heal" with competency testing. On 5/16/2022, the Administrator and DON, in consultation with the Medical Director, reviewed and revised the Lifting Machine, Using a Mechanical Lift Policy to include "perform hand hygiene, don gloves, and disinfect lift. doff gloves and perform hand hygiene" to the beginning and end of using the mechanical lift process. On 5/18/2022, the DON provided personal in-service education on the Personal Protective Equipment-Glove Use Policy, Hand Washing/Hand Hygiene Policy, Lifting Machine Policy, Using a Mechanical Lift, and Standard Precautions Policy to CNA G and H with return demonstration. On 5/18/2022, the DON provided personal in-service education with CNA G and H on the video simulation training on infection control practices titled "Create a Culture of Safety with Partnering to Heal" with competency testing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 Interview on 4/27/22 at 8:10 a.m. with director of nursing (DON) C revealed: *Pockets were not clean, and gloves should not be stored in them. *She expected staff to perform hand hygiene when changing their gloves. Review of the providers September 2012 Infection Control Guidelines for All Nursing Procedures policy did not include proper storage of gloves. 2. Observation on 4/26/22 at 9:50 a.m. of CNAs G and H while performing personal cares for resident 10 revealed: *CNAs G and H had used a mechanical sit-to-stand lift to transfer a resident to the toilet. *Once the resident had been seated on the toilet, CNA H removed her gloves, washed her hands and left the room to obtain incontinent supplies for the resident. *CNA G had stayed with the resident and with her gloved hands she had touched her uniform, the mechanical lift, and her face multiple times. *CNA H returned to the room, and without performing hand hygiene, had put on a clean pair of gloves. *After she performed perineal care, and without removing the soiled gloves, she applied a clean incontinence brief, and pulled up the resident's clothing. *CNA G had used the same pair of gloves throughout the entire process. -She was in charge of moving the resident in the mechanical lift. *CNA H had moved the mechanical lift from the resident's room to the hallway and had not disinfected it before placing it in the hall. -She washed her hands after moving the	F 880	Due to the risk of all residents, beginning 5/20/2022, the DON or her designee will provide mandatory education to all direct care staff on the Personal Protective Equipment- Glove Use Policy, Hand Washing/Hand Hygiene Policy, Lifting Machine, Using a Mechanical Lift Policy, and Standard Precautions Policy with competency testing. Beginning 5/18/2022, the DON or her designee will provide mandatory education to all direct care staff on the video simulation training on infection control practices titled "Create a Culture of Safety with Partnering to Heal" with competency testing. Beginning 5/26/2022, the DON or her designee will perform random observation audits 2x/shift weekly to ensure lift disinfection is being completed as educated and trained. Findings will be reported to the quarterly QAPI committee and audits will continue for as long as the committee deems necessary. Beginning 5/26/2022, the DON or her designee will perform random observation audits 2x/shift weekly to ensure glove use and hand hygiene is being completed as educated and trained. Findings will be reported to the quarterly QAPI committee and audits will continue for as long as the committee deems necessary. Beginning 5/26/2022, the DON or her designee will complete a weekly audit of every room to ensure gloves are properly stored and stocked per the Personal Protective Equipment-Glove Use Policy. The DON or her designee will report findings to the quarterly QAPI committe for as long as the committee deems necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 mechanical lift to the hallway. 3. Observation on 4/26/22 at 10:20 a.m. of CNAs G and H revealed: *CNA H brought the mechanical lift into resident 14's room. *CNAs G and H assisted resident 14 to roll on her side to tuck the lift sling under her. *She had had a bowel movement, so CNA G had used peri-wipes to perform peri-care. -Resident 14's buttocks was very red, so CNA G applied a thick layer of protective ointment. -CNA G changed gloves midway through applying the cream and had removed those gloves from her uniform pocket. -She had not performed hand hygiene prior to putting on new gloves. *They transferred resident 14 to her wheelchair, using the mechanical lift, and CNA H then moved the lift into the hallway. *The lift had not been disinfected prior to removal from the room. Continued observation in the same hallway revealed the lift had not been cleaned prior to CNAs G and H taking it to another resident's room a few minutes after exiting resident 14's room. Interview on 4/26/22 at 9:50 a.m. with CNA H revealed: *She agreed she had forgotten to wash her hands when she had came back into resident 10's room. *She agreed she had not put clean gloves on prior to pulling up resident 10's clothing. *She agreed she had not cleaned the lift prior to taking it from resident 10's room and taking it into resident's 14's room. Neither of us (CNAs G and H) had cleaned the lift prior to taking it from the	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 hall into another unidentified resident's room. Interview on 4/26/22 at 10:10 a.m. with CNA G revealed: *She agreed after she had started putting cream on resident 14's bottom, she had not changed her gloves. *She agreed she had removed those gloves and had taken a new pair from her uniform pocket. -When asked if keeping gloves in her pocket was her usual practice, she said, "Yes, because I have to have a special kind of glove." *She agreed her pocket would be considered 'dirty', so the gloves would be contaminated. Interview on 04/27/22 at 9:50 a.m. with DON C regarding glove use by CNA G and lift cleaning after describing the above observations, she responded "Definitely not! They [staff] have all been trained on proper hand hygiene and that pockets are considered dirty." "The lifts are to be cleaned after each use."	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING _____ B. WING _____	04/27/2022

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

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

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

Deborah Herrboldt | Administrator | 5/19/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10677	A. BUILDING: _____ B. WING _____	04/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) 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 4/25/22 through 4/27/22. Bethany Home Sioux Falls was found in compliance.	S 000		

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

Deborah Herrboldt | Administrator | 5/19/2022

STATE FORM 6899 Y8K611 If continuation sheet 1 of 1

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/27/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/27/22. Bethany Home Sioux Falls was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Deborah Herrboldt | Administrator | 5/19/2022

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.