

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10589	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2014
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NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401
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(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
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S 000 Initial Comments

Surveyor: 32331
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/14/14 through 4/16/14. Bethesda Home of Aberdeen was found not in compliance with the following requirement: S301.

S 000

S 301 44:04:07:16 Required dietary in-service training

The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service training for all dietary and food-handling employees...Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.

This Rule is not met as evidenced by:
Surveyor: 32331
Based on record review, interview, and policy review, the provider failed to ensure:
*Four of nine required annual in-service training sessions (food handling and preparation techniques, food-borne illnesses, leftover food handling policies, and time and temperature controls for food preparation and service) were offered for food-handling staff yearly.
*One of nine required annual in-service training session (food-borne illness) was offered for all dietary staff yearly.
Findings include:

S 301

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Bruce A. Johnson Admin Director

APR 28 2014

APR 28 2014

MAY 12 2014

SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 301	<p>Continued From Page 1</p> <p>1. Record review of the required in-service training sessions for 2013 and 2014 for all food handling staff revealed: *Those staff had received no training on the following: -Food handling and preparation techniques. -Food-borne illnesses. -Leftover food handling policies. -Time and temperature controls for food preparation and service.</p> <p>Interview on 4/16/14 at 8:00 a.m. with registered nurse D regarding required in-service training sessions for 2013 and 2014 for all food handling staff revealed: *Food handling staff were identified as dietary, nursing, activities, and hospitality staff. *There had not been an in-service on food handling and preparation techniques, food-borne illness, leftover food handling policies, and time and temperature controls for food preparation.</p> <p>2. Record review of the required in-service training sessions for 2013 and 2014 for all dietary staff revealed those staff had received no training on food-borne illness.</p> <p>Interview on 4/15/14 at 3:45 p.m. with certified dietary manager C revealed: *They had failed to include a food-borne illness in-service among all dietary staff training topics. *She had been unaware the required dietary staff training topics were to have included food handlers. *Food handlers were identified as dietary, nursing, activities, and hospitality staff.</p> <p>3. Review of the provider's 2010 Training/Orientation policy revealed: *All staff involved in food service were to have</p>	S 301	<p>S301</p> <p>(1,2 &3) This deficiency has the potential to affect all residents.</p> <p>The dietary manager determined there were no negative outcomes to any resident regarding this deficiency.</p> <p>The policy has been revised to identify which staff is required to attend the required dietary training sessions.</p> <p>All staff will be required to attend training sessions on May 13, 2014. The in-service will include food handling and preparation, food-borne illnesses, leftover food handling policies, time and temperature controls for food preparation and service.</p> <p>The nine required in-service training sessions will be done yearly at our Mandatory Extravaganza (scheduled for September 9, 2014) for all staff. All new employees (dietary, nursing, activities, and hospitality staff) will receive training during General Orientation.</p> <p>The Quality Improvement Coordinator will audit that all staff receives the required dietary training and will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.</p> <p>5-13-14</p>

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S 301	Continued From Page 2 been required to participate in regularly scheduled in-service training sessions. *The policy had not identified what staff needed to participate in that specific in-service training.	S 301		

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

ORIGINAL

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F 000	INITIAL COMMENTS Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/14/14 through 4/16/14. Bethesda Home of Aberdeen was found not in compliance with the following requirements: F281, F323, F425, F431, and F514.	F 000	Addendums noted with an asterisk per 5/14/14 telephone to facility administrator and DON. JTK/DDH/MF	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on observation, record review, interview, and policy review, the provider failed to ensure professional standards had been maintained for 2 of 14 sampled residents (7 and 14) for the following: *Physician's orders had not been followed for 1 of 1 sampled resident (14) receiving intravenous (IV) therapy. *Significant and consistent decrease in blood pressure occurred for 1 of 1 sampled resident (7) for three days had not been reported after initial report to physician. *Ensure the dates medication containers were opened for first time use were consistently documented on the medication containers. *Identify medication expiration dates in one of two medication carts and in the medication storage room (north nursing station). Findings include:	F 281		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce Johnson</i>	TITLE Administrator	(X6) DATE May 9, 2014
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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.

APPROVED
MAY 12 2014
If continuation sheet Page 1 of 18
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F 281	Continued From page 1 1. Review of resident 14's medical record revealed: *The resident had been admitted on 4/14/14. *The 4/14/14 hospital electronically signed physician's transfer orders read "Vancomycin (vanc) [antibiotic] 1250 milligrams (mg) in sodium chloride 0.9%. Administer 1250 mg intravenously every 24 hours." *The provider's electronic physician's orders for Vancomycin were: -A 4/5/14 physician's order for "Vancomycin 1000 mg in sodium chloride 0.9% Q (every) 24 H (hours)." That order had been discontinued on 4/8/14. -Another physician's order dated 4/5/14 for "Vancomycin 1 GM (gram) every 24 hours IV." That order had been discontinued on 4/7/14. -Another physician's order dated 4/8/14 for "Vancomycin 1000 mg in sodium chloride 0.9% 250 milliliters (ml) Q 24 H 'IV' per pharmacy dosing after vanc trough (blood test to determine medication dosing)." That order had been discontinued on 4/11/14. -Another physician's order dated 4/11/14 for "Vancomycin 1000 mg in 250 ml of sodium choride [chloride] (0.9%) every 24 hours per pharmacy dosing until Monday, April 14th then discontinue." That order had been discontinued on 4/15/14. -There had been a physician's order on 4/11/14 for "Per pharmacy for Vancomycin trough of 17.7, give 1 gram of Vancomycin in 250 cubic centimeters (cc) NAACL (sodium chloride) IV on 4/11, 4/12, 4/13, 4/14. Then discontinue." The frequency of the order had been daily. That order had been discontinued on 4/15/14. *There had been a physician's telephone order on 4/5/14 that read "Vancomycin 1250 mg in sodium	F 281			

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F 281	Continued From page 2 chloride 0.9% 250 ml Q 24 H 'IV' per pharmacy dosing after vanc trough medication." Review of the medication administration record (MAR) for April 2014 revealed: -"Vancomycin 1000 mg in sodium chloride 0.9% 250 ml Q 24 H 'IV' per pharmacy dosing after vanc trough medication." The medications were to be given on 4/5/14 through 4/8/14. -"Vancomycin 1 GM every 24 hours IV medication daily." The medication was to have been given on 4/5/14 through 4/7/14. -"Vancomycin 1000 mg in sodium chloride 0.9% 250 ml Q 24 H 'IV' per pharmacy dosing after vanc trough. Medication." That medication was to have been given on 4/8/14 through 4/11/14. -"Vancomycin 1000 mg in 250 ml of sodium choride [chloride] (0.9%) every 24 hours per pharmacy dosing until Monday, April 14th then discontinue. Medication daily." The medications were to have been given 4/11/14 through 4/15/14. Review of the provider's 4/4/14 IV Flow Sheet revealed an IV medication order that read Vancomycin Q 24 hours. -There was no indication of dose, rate, or volume to have been infused, or what the medication should have been mixed in. Interview on 4/16/14 at 8:20 a.m. with registered nurse (RN) B confirmed resident 14 did in fact have an order for Vancomycin 1250 mg to be given every 24 hours. She remembered mixing two vials and placing 20 cc from one vial and 5 cc from the other vial which made a dose of 1250 mg. She confirmed the April 2014 MAR was incorrect. Interview on 4/16/14 at 8:40 a.m. with the resident	F 281	F281 This deficiency has the potential to affect all residents. 1) The Director of Nursing has determined there were no negative outcomes to Resident #14 regarding the error in transcribing the order. The policy and procedure for transcribing orders has been reviewed and rewritten. The policy for transcription of IV orders has been reviewed and rewritten. The Director of Nursing will educate all nurses at the nurses meeting on May 13, 2014. A second check by another nurse will be done on all orders to ensure proper entry. The night charge nurse will audit all IV orders on a nightly basis until the Quality Assurance and Performance Improvement Committee decides to discontinue. The night charge nurses will report to the Director of Nursing who will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.	

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F 281	<p>Continued From page 3</p> <p>care coordinator (RCC) A revealed she confirmed the April 2014 MAR had transcription errors, dosing errors, and duplicate orders along with missing nursing initials.</p> <p>*RCC (A) then telephoned the pharmacy and at 8:50 a.m. that same day she gave this surveyor written documentation as to the medication orders the pharmacy had filled and sent to the provider.</p> <p>-On 4/4/14 the provider was to have started the resident on 4/5/14 Vancomycin 1250 mg daily IV through 4/8/14.</p> <p>-Then on 4/9/14 the dose was to have been decreased to Vancomycin 1000 mg IV daily through 4/14/14, and it was to have been discontinued after that dose had been given.</p> <p>Interview on 4/15/14 at 9:00 a.m. with the director of nursing (DON) confirmed the April 2014 MAR was incorrect and had transcription dosing errors and duplicate orders. At 1:30 p.m. that same day the DON stated the order for the Vancomycin had been changed in the electronic medical record. The nurse had not discontinued the initial order and rewritten the new order. The nurse had gone to the initial order and changed the dose which then caused the order to have been incorrect. She also confirmed there was no documentation to show the correct dose had been given. She confirmed she would have expected the nurse to have discontinued the initial order and written a new order.</p> <p>Review of the provider's undated Transcribing Orders policy revealed:</p> <p>"4. Transcribe the new order onto the appropriate form. If a medication has changed dosage &/or times the entire order has to be re-written."</p>	F 281	<p>2) The Director of Nursing has determined there were no negative outcomes to Resident #7 regarding the failure to notify physician of low blood pressures.</p> <p>The policy and procedure on Measuring and Reporting Vital Signs has been reviewed and rewritten.</p> <p>The Director of Nursing will educate all nurses at the nurses meeting on May 13, 2014.</p> <p>The Night RN Supervisor will audit 20 % of residents for accurate documentation and reporting of vitals weekly for 4 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Night RN Supervisor will report to the Director of Nursing who will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.</p>	

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F 281	<p>Continued From page 4</p> <p>Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8 th Ed., St. Louis, MO., 2013, p. 353, revealed "The EHR (electronic health record) provides access to a patient's health record information at the time and place clinicians need it. A unique feature of an EHR is its ability to integrate all pertinent patient information into one record... An EHR includes tools to guide and critique medication administration and basic decision support tools such as physician orders sets and interdisciplinary treatment plans."</p> <p>Review of Lippincott'sNursingCenter.com web site at http://www.nursingcenter.com/Blog/post/2011/05/27/8-rights-of-medication-administration.aspx revealed the Rights of Medication Administration are:</p> <ol style="list-style-type: none"> 1. Right patient. 2. Right medication. 3. Right dose. 4. Right route. 5. Right time. 6. Right documentation. <p>Surveyor: 33265</p> <p>2. Review of resident 7's entire medical record revealed the following: *Resident's blood pressure readings had been: -On 4/7/14 at 1:49 p.m. 142/73. -On 4/8/14 at 9:26 a.m. 151/76. -On 4/8/14 at 5:46 p.m. 132/68. -On 4/9/14 at 6:18 p.m. 156/75. *On 4/9/14 during late afternoon hours the resident's agitation had increased and was not able to be redirected. -A family member had been notified of the</p>	F 281	<p>3,4,&5) The Director of Nursing has determined there were no negative outcomes to Resident #18 or #19 regarding this deficiency.</p> <p>The Quality Improvement Coordinator audited all the medication carts and med room storage cupboards to ensure all medications were properly labeled. Medications were returned to the pharmacy as necessary. This was completed May 7, 2014.</p> <p>The policy and procedure for storage and labeling of medications was reviewed and rewritten.</p> <p>The Director of Nursing will educate all nurses at the nurses meeting on May 13, 2014.</p> <p>The Quality Improvement Coordinator will audit the med carts and med room storage for properly labeled medications weekly for 4 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.</p>	5-13-14

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F 281	<p>Continued From page 5</p> <p>change and requested Haldol (antipsychotic medication) to be given as it had been on 3/30/14.</p> <p>*An unsigned physician order dated 4/9/14 for 1.0 milligram of haldol to be given intramuscularly (IM -injected into the muscle) "now" (7:10 p.m.) for agitation.</p> <p>*The medication administration record showed 1.0 milligram of Haldol had been given IM at 7:15 p.m. on 4/9/14.</p> <p>*The resident's blood pressure readings for April 2014 had been:</p> <ul style="list-style-type: none"> -On 10th at 6:54 p.m. 90/50. -On 11th at 2:50 p.m. 90/60. -On 11th at 6:57 p.m. 90/60. <p>*The return of a fax to the resident's physician revealed:</p> <ul style="list-style-type: none"> -The original message on 4/10/14 at 6:21 p.m. to the clinic stated "update on blood pressures". -The response from clinic physician's assistant on 4/11/14 at 11:58 a.m. and stated "BP" [blood pressures] "received, nno" [no new orders]. -A nurse's note on 4/11/14 at 2:41 p.m. acknowledged receipt of the faxed answer and wrote "will resume weekly BPs." <p>*No additional communication or documentation concerning continued lowered blood pressure readings were found in the remaining medical record.</p> <p>*No blood pressure had been taken since 4/11/14 up to today's date.</p> <p>Interview on 4/16/14 at 1:50 p.m. with the DON revealed:</p> <ul style="list-style-type: none"> *She had no idea if the resident's blood pressure remained low. *She agreed the low blood pressure could have been a problem just as high blood pressure could be. 	F 281		
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F 281	<p>Continued From page 6</p> <p>The provider's policy dated 2006 on Measuring of: Vital Sign Guidelines revealed: *Policy identified an average blood pressure reading of less than 120 over less than 80 millimeters of mercury. -Policy did not address what to do when the blood pressure dropped. *Assessment guidelines within the policy included: -Know the resident's normal range of vital signs.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., Elsevier, St. Louis Mo, 2013, pp. 442 and 461, revealed: *"Know the patient's usual range of vital signs. These values can differ from the acceptable range for that age or physical state. The patient's usual values serve as a baseline for comparison with later findings." *"When vital signs appear abnormal, have another nurse or health care provider repeat the measurement to verify readings." *"Hypotension (low blood pressure) is present when the systolic BP falls to 90 mm Hg or below. Although some adults have a low BP normally, for most people low BP is an abnormal finding associated with illness."</p> <p>3. Observation on 4/16/14 at 9:45 a.m. of the medication cart utilized by RN 5 revealed resident 18's eyedrops had been: *Initially ordered on 6/24/13. *Opened and used without the date of opening having been documented on the bottle.</p> <p>Interview on 4/16/14 at 10:00 a.m. with RN 5 revealed he: *Did not know when the bottle had been initially</p>	F 281		

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F 281	<p>Continued From page 7 opened. *Confirmed the bottle had been opened and was being used.</p> <p>4. Observation on 4/16/14 at 9:15 a.m. of the north medication storage room with RN 2 revealed resident 19's bottle of cough medication: *Had expired in December 2013. *Had been given to the resident on 3/30/14. *Did not have the date it was opened for the first use listed on bottle.</p> <p>Interview on 4/16/14 at 9:40 a.m. with RN 2 revealed she: *Agreed there was no date to identify when the bottle had been opened. *Had not realized that the medication had expired in December 2013. *Was unable to identify which day in the month the medication would have expired.</p> <p>5. Interview on 4/16/14 at 1:50 p.m. with the DON concerning the above findings (3 and 4)revealed she: *Would have expected the date the bottle was opened for use would be listed on the bottle. *Agreed the policy did not address documenting the date a medication container was opened for use. *Agreed the policy did not address which day of the month a medication expired.</p> <p>Review of the 12/15/13 dated storage and labeling of medications and drugs policy revealed there was: *No instructions to include the date the medication container had been opened for use. *No identification as to what date in the identified month (first of month, last day of month) the</p>	F 281		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/16/2014
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 F 323 SS=D	<p>Continued From page 8 medication would have expired.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32573 Based on observation, interview, label review, and material safety data sheet (MSDS) review, the provider failed to ensure: *Hazardous chemicals were not accessible to residents in two of two clean utility rooms (north and south sides) of the facility. *Cleaning wipes were not accessible to residents in one of one dining room. Findings include:</p> <p>1. Observation on 4/14/14 at 5:45 p.m. of the unlocked north clean utility room revealed: *An open cardboard box containing concentrated Penner whirlpool disinfectant cleaner jugs sitting on the counter. *Containers of Clorox disinfecting wipes sitting on the counter. *An open cardboard box containing concentrated Penner bath additive solution jugs sitting on the counter. *A container of Clorox Healthcare germicidal wipes sitting on the counter.</p>	F 281 F 323		

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NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401
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F 323	<p>Continued From page 9</p> <p>*Containers of Clorox disinfecting wipes on the bottom shelf of a rolling wire storage rack.</p> <p>Observation on 4/15/14 at 8:15 a.m. of the unlocked south clean utility room revealed: *An open cardboard box containing concentrated Penner Bath Additive solution jugs sitting on the counter. *An open cardboard box containing Penner Whirlpool Disinfectant Cleaner jugs sitting on the counter.</p> <p>Random observations from 4/14/14 to 4/16/14 revealed the same chemicals remained accessible to residents in the north and south clean utility rooms. The clean utility rooms were kept unlocked at all times.</p> <p>Interview on 4/15/14 at 2:30 p.m. with the maintenance supervisor revealed the maintenance department delivered cleaning supplies to the clean utility rooms on Mondays when new shipments arrived. The night shift certified nursing assistants (CNA) should have put those supplies away that same evening.</p> <p>Interview on 4/16/14 at 9:15 a.m. with the director of nursing confirmed the night CNAs had been responsible for cleaning and organizing the clean utility rooms. Those chemicals should not have been left where residents could have access to them.</p> <p>Review of the Penner whirlpool disinfectant cleaner MSDS dated 6/17/13 revealed it might cause eye and skin irritation. It might be harmful if swallowed or if spray mist was inhaled. That concentrated cleaner had a health hazard rating of moderate.</p>	F 323	<p>F323</p> <p>1) This deficiency has the potential to affect all residents.</p> <p>The Director of Nursing has determined there were no negative outcomes to any resident regarding this deficiency.</p> <p>A walk-thru of the facility was done by the Maintenance Supervisor, Quality Improvement Coordinator and the Corporate Compliance Officer. All chemicals were placed under locked storage.</p> <p>The Quality Improvement Coordinator will audit utility rooms and the dining room for proper storage of chemicals weekly for 4 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The policy and procedure for storage of chemicals has been reviewed and rewritten.</p> <p>All chemicals will be stored in the locked storage rooms in the 300 and 700 wings. Non-disinfecting, non-irritating wipes will be used in the dining areas. Maintenance will deliver all incoming supplies to the locked storage areas.</p>	<p>JTSDH/MF</p>
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F 323	<p>Continued From page 10</p> <p>Review of the Penner bath additive MSDS dated 7/14/11 revealed the concentrated solution might be harmful if swallowed.</p> <p>Review of the Clorox Healthcare germicidal wipes label revealed a precautionary statement that it might contain hazards to humans and pets and causes moderate eye irritation.</p> <p>2. Observation on 4/15/14 at 12:40 p.m. in the dining room revealed a container of Clorox disinfecting wipes sitting on a side table during the lunch meal.</p> <p>Review of the Clorox Disinfecting Wipes label revealed it might cause moderate eye irritation and should not have prolonged contact with skin. The wipes required a potable (able to drink) water rinse if used on surfaces that might come into contact with food.</p> <p>F 425: 483.60(a),(b) PHARMACEUTICAL SVC - SS=D ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p>	F 323	<p>F323 (cont)</p> <p>The Staff Education/Quality Improvement Coordinator will educate all staff at scheduled meetings on May 13, 2014.</p> <p>The Quality Improvement Coordinator will audit the facility for proper storage of chemicals weekly for 4 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.</p>	5-13-14

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F 425	<p>Continued From page 11</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to identify packaging errors of a punch card on one of one randomly observed resident's (20) medication punch card on one of two medication carts at the north nurses station. Findings include:</p> <p>1. Observation on 4/16/14 at 9:45 a.m. of the medication cart utilized by registered nurse (RN) E revealed resident 20's medication punch card containing diphenoxylate atropine (antidiarrheal) medication had been: *Initially ordered on 4/11/13. -Ordered to be given as one tablet three times a day as needed. *Designed to have one tablet in each of the thirty-one bubbles of the card. *Received the punch card with two bubbles with two pills in each (numbers 5 and 13) and two bubbles that were empty (numbers 6 and 14).</p> <p>Interview on 4/16/14 at 1:50 p.m. with the director of nursing revealed she: *Would have expected the punch card to have been filled correctly from the pharmacy. *Agreed the punch card error should have been noticed, and the card should not have been accepted by staff.</p>	F 425	<p>F425</p> <p>1) This deficiency has the potential to affect all residents.</p> <p>The Director of Nursing has determined there were no negative outcomes to Resident # 20 regarding this deficiency.</p> <p>The pharmacy reviewed all of the resident's current medications for the correct packaging on April 17, 2014.</p> <p>The policy and procedure for receiving and checking of medications from the pharmacy has been reviewed and rewritten.</p> <p>The Director of Nursing will educate all nurses at the nurses meeting on May 13, 2014</p> <p>The Quality Improvement Coordinator will audit the medications for proper packaging weekly for 4 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.</p> <p>The Registered Pharmacist will report to the Quality Assurance Committee Quarterly.</p>	5-13-14

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F 425	Continued From page 12 Interview on 4/16/14 at 1:40 p.m. with the pharmacist revealed he agreed a punch card with an error should have been caught at the pharmacy and not have been sent out to the facility. Review of the provider's 12/15/13 Medication Packaging/Labeling policy in the Long Term Care Facility's Pharmacy Services and Procedure Manual revealed medications were: *Packaged in accordance with federal regulations and state laws. *Dispensed in a container appropriate for the accurate administration of each medication.	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431		

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F 431	<p>Continued From page 13 have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation and interview, the provider failed to ensure one of one pharmacy providing medication to the provider used the expiration date for all repackaged medications recommended by the South Dakota Board of Pharmacy in two of two medication carts and in one of one medication storage room in the north nurses' station. Findings include:</p> <p>1. Observation of medication punch cards and liquid containers on 4/15/14 between 7:58 a.m. and 12:40 p.m. in the north nurses station revealed both repackaged scheduled and as needed (prn) medication from the pharmacy had expiration dates exceeding one year from the repackaging date.</p> <p>Interview on 4/16/14 at 1:40 p.m. with the facility's consulting pharmacist regarding expiration dates on repackaged medications exceeding the recommended one year date revealed the pharmacist:</p>	F 431	<p>F431 1) This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to any resident regarding this deficiency.</p> <p>The pharmacy removed and replaced all medications with correct expiration dates on April 17, 2014.</p> <p>The Pharmacist has updated the Policy and Procedure for expiration dates on repackaged medications.</p> <p>The Director of Nursing will educate all nurses at the nurses meeting on May 13, 2014.</p> <p>The Quality Improvement Coordinator will audit repackaged medications for proper expiration dates weekly for 4 weeks then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Quality Improvement Coordinator will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee.</p> <p>The Registered Pharmacist will report to the Quality Assurance Committee Quarterly.</p>	5-13-14

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F 431	Continued From page 14 *Used the expiration date on the medication container as the expiration date for all scheduled and all prn medications repackaged for the facility. *Was unaware repackaged medications were to have had an expiration date of no later than one year from the repackaging date. Board of Pharmacy Administration Rule of South Dakota 20:51:13;02.01 (5) (b) revealed a suitable expiration date shall not be later than the expiration date of the manufacture's container, or one year maximum from the date the drug is prepackaged or repackaged.	F 431			
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 32572 Based on record review, interview, and policy review, the provider failed to document according to their activity documentation policy the	F 514			

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F 514	<p>Continued From page 15</p> <p>participation in or the refusal of activities for 10 of 14 sampled residents (1, 2, 3, 5, 6, 9, 10, 11, 13, and 14). Findings include:</p> <ol style="list-style-type: none"> Review of residents 5's Activity Participation Record revealed activity documentation for: <ul style="list-style-type: none"> *Two days for February 2014. *Three days for March 2014. *Four days from April 1 through April 13, 2014. Review of residents 9's Activity Participation Record revealed activity documentation for: <ul style="list-style-type: none"> *Eight days for February 2014. *Three days for March 2014. *Three days from April 1 through April 13, 2014. Review of residents 14's Activity Participation Record revealed activity documentation for: <ul style="list-style-type: none"> Two days from April 4 through April 14, 2014. <p>Surveyor: 32573</p> <ol style="list-style-type: none"> Review of resident 3's Activity Participation Record revealed activity documentation for: <ul style="list-style-type: none"> *Fifteen days for the month of February 2014. *Eight days for the month of March 2014. *Four days from April 1 through April 15, 2014. Review of resident 11's Activity Participation Record revealed activity documentation for: <ul style="list-style-type: none"> *Five days for the month of February 2014. *Four days for the month of March 2014. *Three days from April 1 through April 13, 2014. <p>Surveyor: 33265</p> <ol style="list-style-type: none"> Review of resident 6's Activity Participation Records revealed activity documentation for: <ul style="list-style-type: none"> *Four days for December 2013. 	F 514	<p>F514 * JH/DDH/ME [REDACTED] This deficiency has the potential to affect all residents.</p> <p>The Activity Director has determined there were no negative outcomes to resident #1,2,3,5,6,9,10,11,13 or 14, regarding this deficiency.</p> <p>The policy and procedure on Activity Assessment was reviewed.</p> <p>Education for all activity staff was held on April 28, 2014. Daily documentation on Activity Participation Records was reviewed. Independent activities, group activities as well as 1:1 visits will be documented on a daily basis.</p> <p>The Activity Director will audit participation records on 50% of residents, weekly for 4 weeks, monthly for 3 months and quarterly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue.</p> <p>The Activity Director will report monthly to the Quality Assurance and Performance Improvement Committee and the Quality Improvement Coordinator will report quarterly to the Quality Assurance Committee.</p>	4-28-14

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F 514	<p>Continued From page 16</p> <ul style="list-style-type: none"> *Four days for January 2014. *Six days for February 2014. *Two days for March 2014. *Three days from April 1 through April 13, 2014. <p>7. Review of resident 13's Activity Participation Records revealed activity documentation for:</p> <ul style="list-style-type: none"> *Three days for March 2014. *Two days from April 1 through April 13, 2014. <p>Surveyor: 16385</p> <p>8. Review of resident 2's Activity Participation Record revealed activity documentation for:</p> <ul style="list-style-type: none"> *Ten days in February 2014. *Eleven days in March 2014. *Six days from April 1 through April 15, 2014. <p>Surveyor: 32331</p> <p>9. Review of residents 1's Activity Participation Records revealed activity documentation for:</p> <ul style="list-style-type: none"> *Ten days for February 2014. *Seven days March 2014. *Five days from April 1 through April 14, 2014. <p>10. Review of residents 10's Activity Participation Record revealed activity documentation for:</p> <ul style="list-style-type: none"> *Eight days February 2014. *Six days for March 2014. *Four days from April 1 through April 14, 2014. <p>11. Interview on 4/16/14 at 8:20 a.m. with the activity director revealed:</p> <ul style="list-style-type: none"> *The Activity Participation Record documentation had not been kept up-to-date. *She agreed the documentation of residents' activities needed to be improved. <p>Review of the provider's undated Initial Activity</p>	F 514		

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F 514	Continued From page 17 Assessment policy revealed: **An activity participation record is maintained for each resident and is to be kept in the activity notes folder until four months are completed." **Following completion of participation records, they are filed in each resident's chart."	F 514		
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/16/14. Bethesda Home of Aberdeen (building 01-original structure) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029 and K056 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to maintain proper separation of hazardous areas in one randomly checked location (oxygen	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE May 9, 2014
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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.

Stamp: MAY 12 2014
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Text: If continuation sheet Page 1 of 3

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NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401	
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K 062	Continued From page 2 2. Observation at 11:20 a.m. revealed a laundry room protected by quick response sprinkler heads. A sprinkler head near the dryers was loaded with lint. 3. Observation at 11:35 a.m. revealed a child daycare room protected by standard response sprinkler heads. A sprinkler head near the daycare lavatory was loaded with lint. Interview with maintenance supervisor at the time of those observations confirmed those conditions. This deficiency affected two of eleven smoke compartments.	K 062	K062 1,2,&3) This deficiency has the potential to affect all residents. The sprinkler heads near the dryers in the laundry area and in the child daycare were cleaned by the maintenance department on May 1, 2014. Western States Fire Protection replaced 8 standard response heads located in the child care area and the 2 corroded sprinkler heads in the dishwashing kitchen area on May 7, 2014. The Maintenance Supervisor will audit that all sprinkler heads are maintained in reliable operating condition monthly and report to the Quality Assurance and Performance Improvement Committee. The Maintenance Supervisor will report monthly to the Quality Assurance and Performance Improvement Committee until all repairs are completed. The Maintenance Supervisor will contact the Administrator once repairs are completed. The Administrator will be responsible for monitoring and follow-up. The Quality Improvement Coordinator will report quarterly to the Quality Assurance Committee.	5-07-14

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

ORIGINAL

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 04/16/2014
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NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/16/14. Bethesda Home of Aberdeen (Building 02 addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce A. Johnson</i>	TITLE Administrator	(X6) DATE May 9, 2014
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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.

MAY 12 2014
SD DOH L&C