

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2014
NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042	
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F 000	INITIAL COMMENTS Surveyor: 12218 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 1/21/14 through 1/23/14. Bethel Lutheran Home was found not in compliance with the following requirements: F226, F253, F323, F371, F431, and F441.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to have documentation to reflect investigations had been completed for incidents regarding neglect and abuse for the following: *One of one sampled resident (2) who had a major injury. Findings include: Surveyor: 32332 1. Review of resident 2's medical record revealed: *On 12/17/13 she had been hospitalized for a femur fracture after being eased to the floor during a transfer. *She had been readmitted on 12/23/13.	F 226	The Administrator, Social Worker, and Director of Nursing (Incident Report Team) reviewed and revised the policy and procedure for "Accident/Incident/Abuse Investigation and Reporting". Education on the revised "Accident/Incident/Abuse" policy and procedure were reviewed with all employees by the Director of Nursing at a mandatory in-service conducted Friday, 2/14/14 at 2:00 p.m. The Administrator, Director of Nursing, and the Social Worker (Incident Report Team) have reviewed the incident reports for the following residents: 2, 21, 22, 23, 13, 10, 15. Risk Safety Committee meeting minutes were also reviewed related to the above incidents.	

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

TITLE

ADMINISTRATOR

(X6) DATE

3/17/2014

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 226	<p>Continued From page 1</p> <p>*An incident report had been filled out when the above incident had occurred.</p> <p>*The medical record had not contained information regarding an investigation as to the cause of the fracture.</p> <p>Surveyor: 32332 Surveyor: 32335</p> <p>2. Interview on 1/23/14 at 10:30 a.m. with the licensed social worker revealed:</p> <p>*They had not been documenting interviews of the residents, CNAs, witnesses, or charge nurses regarding events leading up to the incidents.</p> <p>*They had been more "reactive then proactive" in the investigation process.</p> <p>Surveyor: 32332 Interview on 1/22/14 at 7:05 p.m. with the director of nursing (DON) revealed:</p> <p>*The DON had reviewed the incident report and discussed the events of the incident with the staff member who had eased the resident onto the floor.</p> <p>*The incident report team met weekly on Thursday to review any events that occurred during the week.</p> <p>*Resident 2's femur injury from 12/17/13 had been discussed during their team meeting.</p> <p>*The team had decided it was not necessary to report the injury to the department of health or other entities or to investigate further.</p> <p>Review of the provider's 2/8/05 Resident Abuse policy revealed:</p> <p>*Incident reports and documentation was to have been completed, reviewed, and maintained to identify events, patterns and trends that may have constituted abuse to determine if an investigation was warranted. All unknown origin bruises were</p>	F 226	<p>The Risk Safety Committee instituted a new Briggs form 3308 titled, <i>Preliminary Investigation Report</i>. This report is initiated by the Charge Nurse to ensure that an immediate investigatory process commences at the time of the incident. All witnesses will be required to document their accounts. The residents will be interviewed, if possible. This report will then go to the Director of Nursing for her review, additional investigation/interview if she deems necessary, and will then be referred to the Risk Safety Committee for their review.</p> <p>The Risk Safety Committee or the Incident Report Team (who are also members of the committee) will determine if further investigation/intervention is needed. A procedure for use of this new form/process has been developed.</p>		

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F 226	Continued From page 2 to have been highlighted for identification. *The DON and the social worker would have conducted an initial assessment of the resident. *Written statements would have been obtained by the initial staff members who reported the incident. *Any witnesses to the incident would have been required to submit written statements. *The administrator would have convened an Incident Report Team comprised of the DON, social worker, and others. *The team would have reviewed the occurrence of events from the initial incident up to and including the initial investigative phase of the process.	F 226	The revised policy and procedure for "Accident/Incident/Abuse Investigation and Reporting" and the Briggs form 3308 were presented by the Director of Nursing at the mandatory all staff in-service presented Friday, 2/14/14.	2/14/14	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation and interview, the provider failed to ensure: *The ceiling vent covers in ten of ten sampled residents' (1S, 3S, 6S, 7S, 11S, 14S, 9W, 13W, 1N, and 20N) bathrooms were kept clean and free of lint build-up. *The filters on all five of five beauty salon hair dryers were kept clean and free of lint build-up. Findings include: 1. Random observations on 1/22/14 from 8:30 a.m. to 5:00 p.m. revealed the ceiling vent covers	F 253	The Social Worker will conduct a QA monthly of all preliminary investigation reports related to documentation of witness interview, probable cause, Director of Nursing and Risk Safety Committee review, and follow-up/ Department of Health notification if indicated. She will report her findings to the QA Committee at their quarterly meeting.	2/18/14	

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F 253	<p>Continued From page 3</p> <p>in residents' rooms 1S, 3S, 6S, 7S, 11S, 14S, 9W, 13W, 1N, and 20N were covered with a light gray colored lint.</p> <p>Interview on 1/23/14 at 2:20 p.m. with the maintenance supervisor (MS) during the environmental walk through revealed his staff had not been responsible for the cleaning of the residents' rooms ceiling vent covers. The housekeeping department would have been responsible for the cleaning of those vent covers.</p> <p>Interview on 1/23/14 at 2:20 p.m. with the housekeeping supervisor revealed she had not realized her staff were responsible for the cleaning of those ceiling vent covers.</p> <p>The resident rooms ceiling vent covers had not been placed on a preventative maintenance program for routine cleaning.</p> <p>2. Observation on 1/22/14 at 2:00 p.m. revealed five beauty salon hair dryers with filters. Those filters were full of gray colored lint.</p> <p>interview on 1/22/14 at the time of the above observation with cosmetologist C revealed she had not been aware the beauty salon hair dryer filters had been dirty. She stated the housekeeping department would have been responsible for the cleaning of the hair dryer filters.</p> <p>Interview on 1/23/14 at 11:30 a.m. with the housekeeping supervisor revealed the housekeeping department had not been responsible for the cleaning of the beauty salon hair dryer filters.</p>	F 253	<p>1. Each of our resident bathroom vent covers and the duct area were cleaned by Maintenance personnel. Resident bathroom vent ducts will be cleaned twice a year, in March and in October by Maintenance staff. Housekeeping has added a weekly cleaning of the vent covers to their schedule. The Housekeeping Supervisor is responsible for the weekly cleaning and the Maintenance Supervisor is responsible for the semi-annual cleaning of the ducts. Both will report at the quarterly QA Committee meeting.</p> <p>2. The five dryer filters were cleaned by the main beautician who serves in our beauty salon. She will clean the filters monthly and maintain a written record in the beauty salon. The Housekeeping Supervisor will monitor the record monthly and report the compliance at the quarterly QA Committee meeting.</p>	2/18/14	

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F 253	Continued From page 4 Interview on 1/23/14 at 2:30 p.m. with the MS during the environmental walk through revealed he had not been aware the beauty salon hair dryers had filters and required routine cleaning.	F 253		
F 323 SS=E	Neither the MS or housekeeping supervisor had known who was responsible for the cleaning of the hair dryer filters. 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, label review, and policy review, the provider failed to ensure: *Hazardous chemicals were stored in a safe manner to protect all residents in: -Two of two soiled linen closets (west and north wings). -One of one sink cupboard in the dining room. -One of two counters in the dining room next to the sink. *Proper sling size had been used for one of four sampled residents (6) that needed an Arjo total lift (mechanical equipment used to transfer an individual from one surface area to another) for transfers.	F 323	A new locked cupboard has been ordered for each of the two soiled linen closets. They will be installed by Maintenance personnel. The key for each cupboard will be located in the closet, inaccessible to residents. The Housekeeping Supervisor will check each closet monthly and include her reports at the quarterly QA Committee meetings. The counter and sink area behind the half-wall of the dining room is to have no chemicals on the counter or inside the cupboards. The chemicals in the cupboards and on the counter were discarded. A sign was put up on the wall and under the sink with states, "Please Do Not Place Any Items on the Counter or Under the Sink".	

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F 323	<p>Continued From page 5</p> <p>*Care staff had received and was documented, education for assessment and the safe use of the EZ stand lift per manufacturer's operator instructions for one of one random observation for one of one resident (10). Findings include:</p> <p>1a. Observation on 1/22/14 at 11:15 a.m. of the west and north wings soiled linen closets revealed: *There were no secured locks placed on the entrance doors to the soiled linen closets. *Several unidentified residents had been observed walking past the closets. *The soiled linen closets had shelves containing the following chemicals: -Two Lysol disinfectant spray cans. Caution warnings on the chemical's label stated was flammable, could be an eye irritant, and was to be kept out of the reach of children. -One spray bottle of Spic and Span disinfectant cleaner. Caution warnings on the chemical's label stated was flammable, could be an eye irritant, could cause skin burns, and was to be kept out of the reach of children. -One bottle of Activate 5.25% institutional bleach. Caution warning on the label stated was dangerous and harmful or fatal if swallowed. -One tub of hydrogen peroxide wipes (disinfectant wipes). Caution warnings on the chemical's label stated to not use on the skin as it might result in redness and burning.</p> <p>Observation and interview on 1/23/14 at 2:40 p.m. with the maintenance supervisor (MS), administrator, director of nursing (DON), and housekeeping supervisor during the environmental walk through revealed: *They had been aware of the chemicals stored in</p>	F 323	<p>The Certified Dietary Manager will check monthly for staff compliance and report her findings at the quarterly QA Committee meetings. An updated copy of the <i>Cascade Premier Bathing System and Daily Maintenance</i> instruction manual was acquired online and printed. A DVD demonstrating safe use of the tub was obtained, including belting technique and transfer procedure with the Penner Transfer System. The Director of Nursing covered this technique with bath aides and CNAs who perform bathing on the evening shift and charge nurses at a mandatory inservice conducted Friday, February 14, 2014. The Director of Nursing also covered a second belt, the chest belt, which allows the resident to be secured in an upright position. It is also present for residents who are unable to support themselves in an upright position. The training DVD will become part of the orientation program for charge nurses and CNAs.</p>	

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F 323	<p>Continued From page 6 the soiled linen closets. *They had been unaware the chemicals should have been secured from residents access.</p> <p>Surveyor: 32331 b. Observation on 1/21/14 at 5:35 p.m. in the dining room underneath a sink in an unlocked cupboard revealed: *The following chemicals: -One-half full bottle of Hillyard Quick and Clean Super Citrus Germicidal (kills germs). -One three-fourth full bottle of Lysol Foam Cleaner (a disinfectant). *The following items were stored with the above chemicals: -One full tray of white coffee cups. -One three-fourth full tray of small stainless steel pitchers. -Two blue soaker pads (washable bed pads). -One small coffee carafe. -One white extension cord. -One watering plant pitcher. -One roll of contact paper. -Three folded cloths. -One empty white container. -Two paper towels. -One white plastic bag.</p> <p>c. Observation on 1/21/14 at the same time as the above in the dining room on the counter next to the sink revealed: *On a tray there was one-half full bottle of Lysol Foam Cleaner. *On the same tray as the above were the following items: -An opened package of Prevail washcloths. -An opened box of gloves. -An opened box of straws. -A beverage glass that contained plastic spoons.</p>	F 323	<p>The QA nurse will conduct a random monthly QA on safe belting technique for day and evening baths and report her findings to the QA Committee at their quarterly meeting.</p> <p>The facility is converting to Ergomed slings, which are Arjo compatible. The Restorative Nurse Coordinator will be responsible for determining the size of sling for each resident who utilizes the Arjo lift. The sling size will be determined using the weight range guide provided by the Arjo and Ergomed companies. The Restorative Nurse Coordinator has developed an "Assessment Criteria and Care Plan for Safe Resident Handling and Movement" form. This form will be completed upon admission, quarterly, and when there is significant change in a resident's condition. The sling size for each resident will be documented on the "Assistance Required and Transfer" form.</p>	

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F 323	<p>Continued From page 7</p> <ul style="list-style-type: none"> -An opened package of plastic disposable cups. -One package of cut flower food. -An opened container of Hormel Thick and Easy (a food thickener). <p>*The tray of items was located next to a:</p> <ul style="list-style-type: none"> -Box of napkins. -Box of raspberry tea concentrate. -Box of open straws. -Package of unopened foam cups. <p>Review at the same time and the location as the above regarding the caution labels on the above listed chemicals revealed:</p> <p>*The Hillyard Quick and Clean Super Citrus Germicidal product was:</p> <ul style="list-style-type: none"> -To be kept out of the reach of children. -Hazardous to humans. -To be avoided for contamination with food and food utensils. -An eye and skin irritant. -To be avoided for contact with eyes and skin. <p>*The Lysol Foam Cleaner was:</p> <ul style="list-style-type: none"> -To be kept out of the reach of children. -An eye irritant. -To be avoided for contact with eyes or skin. <p>Interview on 1/22/14 at 5:45 p.m. with the certified dietary manager regarding the items stored underneath the sink and on the tray on the counter next to the sink in the dining room revealed:</p> <p>*The chemicals should not have been stored with food and other resident items.</p> <p>*There should not have been anything stored underneath the pipes in the cupboard below the sink.</p> <p>*Residents could have had access to that area.</p> <p>Interview on 1/23/14 at 8:00 a.m. with the</p>	F 323	<p>This form will be kept in the binders in the neighborhood wallaroos, making them readily available to the aides, nurses, restorative staff, and therapists. This form will be updated monthly or more often, as needed, by the Restorative Nurse Coordinator.</p> <p>The slings will be placed in individual totes in the storage room, according to size. The totes will be marked with the sling size and corresponding color. The QA nurse will check with nursing and restorative staff monthly regarding availability of slings to ensure availability of appropriate sizes. The Restorative Nurse Coordinator or her designee will conduct a monthly QA on residents requiring an Arjo lift transfer to determine proper sling size use. She will report her findings to the QA Committee at their quarterly meetings.</p> <p>Resident 10 was reassessed for appropriateness/safety of using the EZ Stand lift. The assessment was conducted by a registered physical therapist.</p>		

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F 323	<p>Continued From page 8</p> <p>housekeeping supervisor regarding the items stored underneath the sink and on the tray on the counter next to the sink in the dining room revealed chemicals needed to have been locked up when not in use by staff.</p> <p>Review of the provider's undated Poisonous and Toxic Materials policy revealed: *The chemicals were to have been stored in areas away from the food service area. *Bactericides (kills bacteria), cleaning compounds, or other compounds should not have constituted a hazard to employees or residents. *No information regarding chemicals to have been locked up when not in use by staff. Surveyor: 32331</p> <p>2. Observation on 1/22/14 at 9:10 a.m. in resident 6's room with CNA F and CNA G revealed: *Resident 6 was transferred in a sling with an Arjo total lift from his wheelchair to his bed. *A sling was used in the transfer that had a blue-colored trim along the edge. *The sling's head support area was not behind the resident's head. *The sling size used in the transfer had been an extra large.</p> <p>Interview on 1/22/14 at 9:15 a.m. in the storage room in the west wing with CNA F regarding the sling used for resident 6's transfer revealed: *The sling used had not been the appropriate size. *The sling had been too large for the resident. *He was not a large man, and he had needed a smaller size sling. *The sling used had been an extra large size with a blue-colored trim along the edge. *He had needed a size large with a green-colored trim along the edge.</p>	F 323	<p>A copy of the new <i>EZ Way Smart Stand Operator's Manual</i> was printed (revised 7/17/13). The representative and trainer from EZ Way, Inc. was contacted to consult regarding the appropriateness of using the EZ Stand lift to transfer residents who are unable to stand erect. A training video was purchased from EZ Way, Inc. The Restorative Nurse Coordinator has developed an "Assessment Criteria and Care Plan for Safe Resident Handling and Movement" form. This form will be completed upon admission, quarterly, and when there is a significant change in a resident's condition. An algorithm has been developed for determining the amount and type of assistance required by a resident. The algorithm will be utilized as part of the assessment form listed above.</p>	

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F 323	<p>Continued From page 9</p> <p>*There had not been the correct size sling available for the resident.</p> <p>*That had happened before where the appropriate sized sling had not been available for resident's transfer.</p> <p>*He was harder to position in the sling if it was too large or too small.</p> <p>Review of resident 6's complete medical record revealed: *He had been admitted on 9/7/11. *His diagnoses had included: -Dementia (a change in memory, thinking, language, judgment, and behavior). -Abnormality of gait (a pattern of movement). -Malaise (a feeling of discomfort) and fatigue. *He was to have been transferred with an Arjo lift with two people assisting.</p> <p>Review of resident 6's 1/15/14 care plan revealed: *He was to have been transferred safely with the total lift. *He had needed total assistance with transfers, hygiene, and bed mobility. *He had a history of falls. *The size of the sling to have been used for transfers was not written on the plan.</p> <p>Review of resident 6's 1/8/14 Minimum Data Set assessment revealed his recorded weight was 129 pounds and his height was 62 inches.</p> <p>Interview on 1/23/14 at 1:25 p.m. with the DON regarding the usage of a sling with the Argo total lift for resident 6 revealed: *The appropriate size sling needed to have been used for him. *A sling with the size of very large with the</p>	F 323	<p>The Director of Nursing presented the assessment form, the algorithm, the training DVD was shown, and the "EZ Way Smart Stand Competency Checklist" was reviewed at a mandatory in-service presented on Friday, 2/14/14. The training DVD and competency checklist will become part of the orientation program for new CNAs and nurses. The DVD and competency checklist will be repeated on a yearly basis as a refresher training opportunity.</p> <p>Monthly QAs on EZ Stand lift transfers will be conducted randomly by the QA Nurse and presented to the QA Committee at their quarterly meeting.</p>	3/10/14

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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042
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F 323	<p>Continued From page 10</p> <p>blue-colored trim would have been too large for him.</p> <p>*The sizing of the slings available for use with the Argo total lift system had colored coded trims to reflect the sizes.</p> <p>*The sizes of the Ergomed (the name of the supplier) slings were:</p> <ul style="list-style-type: none"> -Small with red-color coded trim. -Medium with yellow-color coded trim. -Large with green-color coded trim. -Very large with blue-color coded trim. <p>*The CNAs determined which sling to use with input from the restorative nurse or aide and from the charge nurse.</p> <p>*There was not a list available of what sling sizes the staff were to have used for those residents that required slings.</p> <p>Interview on 1/23/14 at 2:26 p.m. with registered nurse E regarding the usage of a sling with the Argo total lift for resident 6 revealed the appropriate size of the sling:</p> <ul style="list-style-type: none"> *Was to have been assessed and decided by the restorative nurse and the charge nurse. *Had not been written down anywhere. *Would not have been the blue-color coded trim, as that would have been too large for him. *Was to have been in his room. *Needed to have been used for his safety. <p>Interview on 1/23/14 at 3:12 p.m. with CNA H regarding the usage of the appropriate slings for residents that required total assistance with transfers revealed:</p> <ul style="list-style-type: none"> *The size of the slings had come from therapy or it had been written in the communication log. *The slings were color coded on the trim on the edges and that determined the size of the sling. *The appropriate slings were to have been placed 	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 11</p> <p>in the residents' rooms who required a total lift for transfers.</p> <p>*The sizes of the slings for residents that had needed them were not written on their daily care sheets.</p> <p>Review of resident 6's 12/5/13 Sunset West Wing Care Sheet revealed:</p> <p>*He was a safety risk.</p> <p>*He had needed transferring with two staff assistance with the Arjo lift.</p> <p>Review of the December 2005 Arjo lift manufacturer's Maxi Move Operating and Product Care Instructions revealed the correct size of the sling should have been ready when using the lift.</p> <p>Surveyor: 32335</p> <p>3. Observation on 1/23/14 at 10:15 a.m. of resident 10 revealed:</p> <p>*CNA J and CNA K had gone into her room to assist her off the commode.</p> <p>*They were using the EZ stand lift to transfer her from the commode to her wheelchair.</p> <p>*During that transfer CNA J had operated the controls and CNA K had been behind her.</p> <p>*After being prompted resident 10 had lifted her hands to hold on to the padded handles.</p> <p>*Her feet had been placed on the platform, but her shins had not been positioned against the shin pads.</p> <p>*When CNA J had lifted her off the commode her elbows bent outward as she was raised up.</p> <p>*She had grimaced at that time.</p> <p>*CNA J had raised her mid-way into the air.</p> <p>*She was positioned with her buttocks suspended approximately six inches above the commode with her legs left free.</p> <p>*CNA K had then moved the commode out from</p>	F 323		

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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 12</p> <p>under her, cleaned her, and then pulled up her pants. *They then transferred her to her wheelchair. *She had not been in a standing position during any of that transfer.</p> <p>Interview with CNA J and CNA K during and after they had transferred resident 10 to her wheelchair revealed: *The day shift was using the EZ stand lift with her and the evening staff had been using the Arjo total lift. *They had received training on how to use the EZ stand lift when they had started employment. *CNA J had been employed for six months. *CNA K had been employed for four years. *They had received hands-on training but had not watched a video, completed a competency test, or read the manual. *They had not had any other training.</p> <p>Interview on 1/23/14 at 3:50 p.m. with RN E regarding resident 10 revealed: *The day shift staff had been using the EZ stand lift and the evening shift had been using the Arjo lift for the resident. *They had been using the EZ stand lift, so she could use the commode during the day. *She had assessed the resident and she had been able to bear weight.</p> <p>Review of the March 2009 EZ Way Stand Operator's Instructions revealed: *Patients (residents) should have been able to bear some weight, should have had upper body strength, and should have been able to follow simple commands. *If a patient had not met each of the three above criteria the EZ stand lift should not have been</p>	F 323		

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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 13 used.</p> <p>**For safe operation of the EZ Way stand, operators should watch the training video, read through the manual, complete a competency checklist, and practice on fellow staff members before use with patients.**</p> <p>*When transferring the resident the operator should have:</p> <ul style="list-style-type: none"> -Placed the residents' feet on the foot plate. -Positioned their shins into the shin pad. -Stopped lifting when the patient was in the standing position. <p>Interview and review of the operator's instructions for the EZ Way Stand on 1/23/14 at 5:30 p.m. with RN E and RN L revealed:</p> <ul style="list-style-type: none"> *RN E had printed the March 2009 EZ Way Stand Operator's Instructions from the company website. *RN E provided basic training on all lifts during the new employee's orientation day. *RN L provided hands-on training to all new employees. *They had not used a video, competency checklist, or manual to train new employees on the EZ stand lifts. *No other trainings had been conducted with employees on the EZ stand lift after they had started. <p>Interview and review of restorative notes on 1/23/14 at 5:45 p.m. with RN E regarding resident 10 revealed:</p> <ul style="list-style-type: none"> *No assessment form had been completed to determine if she was able to bear weight. *She had documented that information in the restorative notes. *She had completed restorative notes on 12/4/13, 12/9/13, and 1/8/14. 	F 323		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 14 *None of those notes had indicated if she was able to bear weight.	F 323			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to maintain proper sanitation conditions of foods stored with non-food items in one of two resident refrigeration unit (activities room). Findings include: 1. Observation on 1/22/14 at 3:30 p.m. in the activity area revealed a refrigeration unit for resident use. In the refrigerator freezer non-food items were being stored with food items. *The items consisted of the following: -Four small-sized Colpac ice packs. -Two large-sized Colpac ice packs. -One blue ice pack located next to a bag of frozen bananas. -Two five-pound packages of ice cubes. *The same freezer area contained ice cubes in the ice bin.	F 371	1. A Haier 1.3 cubic foot upright freezer was ordered and will be placed in the Restorative Room. It will be used to store the Colpac ice packs as well as packaged ice for restorative or therapy use. No non-food items utilized by restorative or therapy will be stored in the refrigeration unit in the activity area. 2. The Certified Dietary Manager and Consulting Dietician met on 2/11/14 with Dietary staff on the deficiencies that were found and the corrective measures that were needed. Dietician talked with both Dietary and Activities personnel on 2/11/14 regarding that there can be no non-food items mixed with food items in the refrigerator. Also discussed was that no outside food can be stored in a refrigerator that is for resident us.		

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

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F 371	<p>Continued From page 15</p> <p>Interview on 1/22/14 during the above observation with activity assistant I revealed: *The ice packs had been used by therapy for residents' care. *The packaged ice cubes were used by both the activities and therapy departments. *The ice cubes in the ice bin were used by activities for residents' use.</p> <p>Interview on 1/22/14 at 4:10 p.m. with registered nurse E regarding the non-food items stored in the refrigeration unit in the activity room revealed: *The ice packs were used for residents' care and treatment by therapy. *The packaged ice cubes were shared between the activities and therapy departments. *She agreed the food and non-food items should not have been stored together.</p> <p>Interview on 1/22/14 at 4:55 p.m. with the activity director regarding the non-food items stored in the refrigeration unit in the activity room agreed the food and non-food items should not have been stored together.</p> <p>Interview on 1/22/14 at 5:45 p.m. with the certified dietary manager regarding the non-food items stored in the refrigeration unit in the activity room agreed the food and non-food items should not have been stored together.</p> <p>Review of the provider's January 2014 Food Storage policy revealed food storage areas were to have been maintained in a clean, safe, and sanitary manner.</p>	F 371	<p>The Activity Coordinator has the responsibility to monitor the use of the refrigerator and report any instances where non-compliance with the use of the refrigerator is noted. The Activity Coordinator will report quarterly at the QA Committee meeting of her findings.</p>	3/1/14
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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

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F 431	<p>Continued From page 16</p> <p>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.</p> <p>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.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</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: 32332 Based on observation, record review, interview, and policy review, the provider failed to:</p>	F 431	<p>1. The key was removed from the padlock affixed to the E-kit and placed on a secured key ring. Numbered zip locks were obtained from Omnicare. An "E-Kit Tamper-Proof Seal Tracking Form for Skilled Nursing Facilities" was obtained. The zip locks will be placed on the E-Kit. Nurses entering the kit will utilize the above form to document the date, time, lock number removed, new lock number, and their signature. The padlock will also remain on the kit. The Director of Nursing demonstrated the zip lock system and documentation requirements to the nurses at a mandatory in-service conducted Friday, 2/14/14. The Director of Nursing will conduct a QA on the security of the E-Kit and corresponding documentation monthly and report her findings to the QA Committee at their quarterly meetings. The Omnicare nurse will continue to perform quarterly medication room and mediation cart audits.</p>		

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F 431	<p>Continued From page 17</p> <ul style="list-style-type: none"> *Maintain secure storage for one of one emergency drug kits stored in the medication room. *Ensure a system was in place to account for three of three controlled medications awaiting destruction in the medication room. *Properly label expiration dates for three as needed (PRN) medications in one of two medication carts containing PRN medications (Northwoods). *Prevent multiple labeling for two of two PRN hydrocodone/APAP blister seal packages for one resident (16) on the Northwoods medication cart. <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 1/23/14 at 11:00 a.m. accompanied by the Minimum Data Set (MDS) coordinator of the emergency drug kit in the medication room, revealed: <ul style="list-style-type: none"> *The kit was stored in an unlocked cupboard. *The kit was sealed with a padlock. *The padlock key remained in the key hole. *The emergency kit contained multiple medications including schedule II, III and IV (government controlled such as narcotics for pain) medication. <p>Interview at that time with the MDS coordinator revealed:</p> <ul style="list-style-type: none"> *She had not known if the key was supposed to have remained in the lock of the emergency kit. *The MDS coordinator, director of nursing (DON), and the charge nurses had keys to the medication room. *There would have been no way of knowing who had been in the emergency drug kit, when they had been in the kit, or what they had removed. <ol style="list-style-type: none"> 2. Observation on 1/23/14 at 11:10 a.m. of the 	F 431	<p>Her findings will be documented on a checklist form, reviewed by the Director of Nursing and the charge nurses, and are kept on file in the Resident Care Coordinator/Nursing Support Specialist office.</p> <p>2. Schedule II documentation forms with a declining inventory and a count conducted by incoming and outgoing charge nurses are utilized. This form accompanies the Schedule II medication, when placed into the disposition cupboard to await destruction. The PRN schedule III and IV medications are also documented on a declining inventory form. This form also accompanies these medications into the disposition cupboard. A form was developed for non-PRN medications that have been completed or discontinued. This form will require the date, time, medication/dose, Rx number, number of tabs/caps/ccs remaining, disposition (place is disposition cupboard), and nurse signature.</p>	

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

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F 431	<p>Continued From page 18 medication room accompanied by the MDS coordinator revealed:</p> <ul style="list-style-type: none"> *A locked cupboard containing three blister seal packages of medications awaiting destruction by the consulting pharmacist. *Those medications were: <ul style="list-style-type: none"> -Tramadol (for pain) 50 milligrams (mg), one tablet remained in the blister package. -Tramadol 50 mg, two tablets remained in the blister package. -Hydrocodone (for pain) 5/500 mg, one tablet remained in the blister package. <p>Interview at that time with the MDS coordinator revealed:</p> <ul style="list-style-type: none"> *Nurses placed discontinued medication awaiting destruction by the pharmacist on his next visit in the cupboard. *The MDS coordinator, DON, and charge nurses had keys to the cupboard. *The nurses who placed the medication in the cupboard would not document how many tablets remained in the blister sealed packages. *The pharmacist would not have known how many tablets had been placed in the cupboard for destruction. *The medications would not have been accounted for by any type of documentation. <p>3. Observation on 1/23/14 at 9:55 a.m. during a review of two of two medication carts containing PRN medications (Northwoods and Sleepy Pines) revealed three PRN medication blister sealed cards on the Northwoods medication cart with no expiration dates on their labels:</p> <ul style="list-style-type: none"> *Resident 16 had two blister sealed packages of hydrocodone/APAP. *Resident 5 had one blister sealed packages of benzonatate (for cough). 	F 431	<p>This form will accompany the blister pack into the disposition cupboard.</p> <p>All of these forms are to be affixed to the medication container with a rubber band. The medications are placed into a locked cupboard in a locked medication room. The Director of Nursing presented the new form and re-educated nurses on the currently utilized forms to ensure safety related to scheduled medications at a mandatory in-service conducted Friday, 2/14/14. The Director of Nursing will conduct a monthly QA on scheduled medications awaiting disposition and report her findings to the QA Committee at their quarterly meetings.</p> <p>A written reconciliation of the following medications (Tramadol 50 mg (1 tablet), Tramadol 50 mg (2 tablets) and Hydrocodone 5/500 mg (one tablet) was done by the Director of Nursing, found to be correct, and the written findings were submitted to the Department of Health.</p>	3/3/14

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F 431	<p>Continued From page 19</p> <p>Interview at that time with RN D revealed: *The medication expiration dates were monitored by the night nurse. *She had been unsure how often the expiration dates were monitored. *She would not have known when those blister packages had been sent by the pharmacy.</p> <p>4. Observation on 1/23/14 at 9:55 a.m. during a review of the Northwoods wing medication cart with RN D revealed: *Resident 16 had two PRN medication blister sealed packages of hydrocodone/APAP. *Those packages had no expiration dates on their labels. *RN D peeled the top labels off the label area to reveal an older label underneath.</p> <p>Interview at that time with RN D revealed: *She had not known why the cards had new labels placed on top of the older ones. *The new labels had been updated with a different physician's name. *She had not known who had placed new labels on the cards. *The cards were not allowed to leave the building, because they had been filled with schedule III (controlled) medication.</p> <p>5. Interview on 1/23/14 at 3:40 p.m. with the DON revealed: *The emergency drug kit had not been secure. It should have been secured with a device indicating when it had been accessed. *There had not been a system in place to account for the medications awaiting destruction. *All PRN medication labels should have included expiration dates.</p>	F 431	<p>3. The Chief Pharmacist at Lewis Drug in Madison was notified of the lack of expiration dates on the three as needed medications in one of two medication carts containing PRN medications. She states that she will "ensure that medication blister packs have expiration dates affixed by the pharmacy". The Director of Nursing directed nurses to check expiration dates carefully and to refuse to accept medications from the pharmacy that do not contain this information. Should a medication require return to the pharmacy due to lack of expiration date, the nurses are directed to call and notify the pharmacy that they will need to correct the missing expiration date and ensure that the facility receives a corrected delivery of the medication to prevent an interruption in medication administration for the resident. Nurses were reminded that checking for an expiration date is their responsibility as part of medication administration.</p>	

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

PRINTED: 03/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/23/2014
NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042		
(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 431	<p>Continued From page 20</p> <p>*She had not known why resident 16 had two sets of labels on her hydrocodone/APAP or who had placed them there.</p> <p>*Medications should not have had more than one label.</p> <p>Review of the provider's 5/1/10 LTC (long-term care) Facilities Receiving Pharmacy Products and Services from Pharmacy policy revealed:</p> <p>*The emergency medication supply kit should have been stored in a secured location.</p> <p>*The provider would ensure that each drawer of the kit was secured in a manner that allowed the pharmacy to identify which emergency medication supplies had been accessed.</p> <p>Review of the provider's 5/1/10 Inventory Control of Controlled Substances policy revealed:</p> <p>*The provider should have maintained separate individual controlled substance records on any medication with a potential for abuse or diversion (theft) in the form of a declining inventory using the "Controlled Substance Declining Inventory Record."</p> <p>*The provider was directed to "remove medications that are completed or discontinued from the inventory, pursuant to the Controlled Substance Verification/Shift Count Sheet; and Reconcile the number of doses remaining in the package to the number of remaining doses recorded on the Controlled Substance Verification/Shift Count Sheet."</p> <p>Review of the provider's 5/1/10 Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles policy revealed:</p> <p>*The provider should have destroyed and reordered medications with soiled, illegible, worn, makeshift, incomplete, damaged, or missing</p>	F 431	<p>This information was presented to nurses at a mandatory in-service conducted on Friday, 2/14/14. Day shift charge nurses will conduct a monthly QA of their medication carts, including Sunset West neighborhood, related to expiration dates present on all medications and report their findings in writing to the Director of Nursing. The Director of Nursing will report to the QA Committee at their quarterly meetings.</p> <p>4. The Chief Pharmacist at Lewis Drug in Madison was notified of the situation were "Resident 16 had two PRN medication blister sealed packages of hydrocodone/APAP. Top labels were peeled off to reveal an older label underneath. The new labels had been updated with a different physician's name". The Pharmacist states that she will speak with her staff and make every attempt to ensure that this situation does not recur.</p>	

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F 431	Continued From page 21 labels. *The provider should have ensured all controlled substances were stored in a manner that maintained their integrity and security. *The provider should have requested that pharmacy performed a routine nursing unit inspection to assist in complying with laws relating to proper storage, labeling, security, and accountability of medications. Review of the provider's 5/1/10 General Dose Preparation and Medication Administration policy revealed staff should have checked expiration dates on the medication prior to administering the medication.	F 431	The Director of Nursing has directed nurses to refuse any medication delivered to the facility that has multiple labels present. This was presented to nurses at an in-service conducted on Friday, 2/14/14. Day shift charge nurses will conduct a QA on the medications in their medication carts as well as the medication cart from Sunset West to ensure that medication containers have only one label present. They will present their findings in writing to the Director of Nursing who will report to the QA Committee at their quarterly meeting.	3/3/14	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441			

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

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NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042		
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F 441	<p>Continued From page 22</p> <p>isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained: *To prevent cross-contamination after disinfecting one of one whirlpool tub. *To ensure sanitary technique was used after the removal of one of one catheter bag for one of one sampled resident (20). *For residents' personal care items in two of ten observed residents' bathrooms (11S and 14S). Findings include:</p> <p>1. Observation on 1/22/14 at 9:00 a.m. of certified nursing assistant (CNA) A prior, during, and after the disinfecting of the whirlpool tub revealed: *She had not washed or sanitized her hands prior to disinfecting the tub. *Without gloves on she touched the following: -The seat of the whirlpool tub two times.</p>	F 441	<p>1. "The Cascade Premier Whirlpool Cleaning and Disinfection" policy and procedure was updated. The revised policy and procedure includes hand washing as well as the use of goggles and gloves. An updated <i>Safe Operation and Daily Maintenance</i> instruction manual was printed. A training DVD and a laminated step-by-step chart were ordered and received. The chart will be placed in the tub room for easy referral for all procedures related to operation and cleaning of the bathing system. The procedure for cleaning and disinfecting the Cascade Premier Whirlpool was provided to nursing staff and reviewed by the Infection Control Nurse at a mandatory in-service conducted Friday, 2/14/14. The training DVD will become part of the orientation program for all CNAs and nurses.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 23</p> <ul style="list-style-type: none"> -The wire attached to the drain plug. -The controls to add the disinfectant solution. -The safety belt (device used to secure the resident in place during bathing). -A large handled brush used for scrubbing the whirlpool tub. *She had not worn gloves during the entire disinfecting process. *She had not washed or sanitized her hands after disinfecting the tub. *She retrieved a clipboard with papers attached to it and charted. *She retrieved another clipboard with papers attached to it. *She left the room to make a copy of one of the above sheets for this surveyor. <p>Interview at the time of the above observation with CNA A confirmed:</p> <ul style="list-style-type: none"> *She would not have always worn gloves when disinfecting the whirlpool tub. *She should have sanitized or washed her hands prior to and after disinfecting the tub. <p>Interview on 1/23/14 at 10:10 a.m. with the director of nursing (DON) and infection control nurse confirmed:</p> <ul style="list-style-type: none"> *Improper technique had been used for the disinfecting of the whirlpool tub. *There had not been any documented audits on whirlpool tub cleaning. <p>Review of the provider's undated Whirlpool Tub Cleaning and Disinfecting policy revealed CNA A should have worn gloves during the disinfecting process to prevent skin irritation only.</p> <p>2. Observation on 1/22/14 at 9:30 a.m. of CNA A revealed:</p>	F 441	<p>The Infection Control Nurse will conduct a monthly QA at random times on cleaning and disinfecting the Cascade Premier Whirlpool. She will report her findings to the QA Committee at their quarterly meetings.</p> <p>2. The procedure for "Catheter Care" has been reviewed and revised. The procedure covers glove use, hand washing, and steps to prevent cross-contamination. This revised procedure was presented to nursing staff by the Infection Control Nurse at a mandatory in-service on Friday, 2/14/14. The Infection Control Nurse has also met with CNA A to discuss prevention of cross contamination when wearing gloves. The Infection Control Nurse will QA the proper handling of catheters and drainage bags/leg bags on a monthly basis at random times and present her findings to the QA Committee at their quarterly meetings.</p>	

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

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F 441	<p>Continued From page 24</p> <p>*She had been assisting resident 20 with the removal of her catheter bag prior to her shower. *After she properly disconnected the catheter bag she:</p> <ul style="list-style-type: none"> -Opened one of resident 20's closet drawers to retrieve a clear plastic container used to measure urine. -Emptied the urine contents from the catheter bag into the container, and then emptied it into the toilet. -Placed the catheter bag in the garbage. -Turned on the faucet water and rinsed the graduate of its urine contents. -Emptied the water from the graduate into the toilet and flushed the toilet. -Retrieved a spray bottle of perineum (area between the thighs) cleanser from resident 20's closet. Sprayed the inside of the graduate with the cleanser. -Replaced the cleanser back in the closet. -Opened the same closet drawer as before and replaced the graduate back inside. -Removed her gloves and washed her hands. <p>*She had worn the same gloves and had not washed or sanitized her hands during the entire process above.</p> <p>Interview on 1/23/14 at 10:15 a.m. with the DON and infection control nurse regarding the above observation confirmed: *Improper technique had been used and cross-contamination had occurred. *There had not been any documented audits on catheter care.</p> <p>Review of the provider's undated Catheter Care, Urinary policy revealed: *The staff were to have assembled all necessary equipment and supplies prior to the procedure</p>	F 441	<p>3. A policy and procedure for "Storage of Resident Personal Care Items" has been developed. Resident personal care items including, but not limited to, hair combs, brushes, picks, tooth/denture brushes, denture cups, colognes/body sprays/powders will be labeled with the resident's name or initials using a black permanent marker or the label machine if they are stored in the resident's bathroom. The items do not require labeling if they are stored in the resident's room. Personal care items are stored on the shelved areas of their closet in their room or in a drawer unit in the resident's bathroom, depending on resident preference. The shelves of the closet will be labeled to allow individualized grouping of oral hygiene, personal care, and hair care items. If a drawer unit in the bathroom is utilized, the appropriate drawers will be labeled with the resident's name using the label machine.</p>		

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F 441	<p>Continued From page 25 and take them to the bedside. *The staff were to have washed their hands prior to catheter care and when they had finished. *Gloves were to have been removed after catheter care.</p> <p>3. Observation on 1/21/14 from 5:00 p.m. to 5:45 p.m. revealed: *All resident's bathrooms on the south wing had been shared with the rooms adjacent to them. *A three compartment cart in bathrooms 11S and 14S. *The carts contained multiple resident care items co-mingled together. Those items included several: -Bottles of lotions. -Bottles of perfume. -Containers of deodorant. -Brushes with black/gray colored hair in them. -Toothbrushes. -Bottles of powder. -Spray bottles of perineum cleaner. -Bottles of body wash. *All of the above resident care items had not been labeled with individual resident's names.</p> <p>Interview at the time of the observation with CNA B revealed: *Most of the resident care items should have been labeled. *She had stated "We usually know whose are whose." *She would have had to check with the charge nurse for any further information regarding the above observation.</p> <p>Interview on 1/23/14 at 10:20 a.m. with the DON and infection control nurse confirmed the above resident care items should have been placed in</p>	F 441	The Infection Control Nurse or her designee will QA the storage of resident personal care items monthly and report their findings to the QA Committee at their quarterly meetings.	2/18/14	

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

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NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042		
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F 441	Continued From page 26 their own compartments and have been individually labeled for each resident. No policy and procedure for proper storage and labeling of resident's personal care items had been provided when requested by this surveyor.	F 441			

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

ORIGINAL

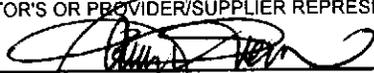
PRINTED: 02/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 1/23/14. Bethel Lutheran Home 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 	TITLE ADMINISTRATOR	(X6) DATE 2/18/2014
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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.

FEB 21 2014

If continuation sheet Page 1 of 1

SD DOH L&C

SOUTH DAKOTA DEPARTMENT OF HEALTH

ORIGINAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10644	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2014
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NAME OF PROVIDER OR SUPPLIER BETHEL LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 S EGAN AVE MADISON, SD 57042
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S 000	<p>Initial Comments</p> <p>Surveyor: 12218 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 1/21/14 through 1/23/14. Bethel Lutheran Home was found in compliance.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrative (X6) DATE 2/18/2014
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