

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON	STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005
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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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F 000	INITIAL COMMENTS Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 8/10/15 through 8/13/15. Bethany Home - Brandon was found not in compliance with the following requirements: F281, F311, F371, and F425.	F 000	*Addendums filed with an asterisk per 9/17/15, telephone from Facility DON, NR/SDDO/H/EL	
F 281 SS=E	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: 33265 A. Based on observation, interview, and record review, the provider failed to clarify differences between physicians' orders, medication administration instructions on the electronic medication administration record (EMR), and instructions on medication containers supplied by the pharmacy for 7 of 27 randomly observed medication administrations which involved residents 17, 18, 19, 20, 21, 22, and 23. Findings include: 1. Observation and interview on 8/10/15 at 5:13 p.m. with licensed practical nurse (LPN) C regarding resident 17's medication order for sertraline hydrochloride (used for depression) revealed: *The EMR said to give at 5:00 p.m. *The label on the medication punch card said to give in the morning at 8:00 a.m.	F 281	The physician's orders, medication label, and e-mar for residents identified were audited by Omnicare pharmacy nurse on 8/20/2015 [REDACTED] Beginning 9/14/2015 physician's orders, medication label, and e-mar for each existing resident will be reviewed by DON or her designee for accuracy as they come due for their next scheduled quarterly care conference. Prevention of future issues will be ensured through the following process, which will take place beginning 9/9/2015: new orders will be entered by trained Bethany staff & double noted by Bethany nurse. The discrepancies will be corrected by DON or her designee by 9/25/15.	17, 18, 19, 20, 21, 22, 23 NR/SDDO/H/EL and all other residents will be completed by 9/25/15 NR/SDDO/H/EL 9/25/15 NR/SDDO/H/EL

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jane Gulickson, Administrator</i>	TITLE	(X6) DATE 9/3/15
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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.

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F 281	Continued From page 1 *The physician's order said to give one daily. *She remembered when the medication started a pharmacist advising they should give it in the evening as it would help the resident sleep. That was why it was scheduled for 5:00 p.m. although the instructions on the card said to give it in the morning at 8:00 a.m. -No documentation on the above instructions was found. 2. Observation and interview on 8/11/15 at 10:45 a.m. with registered nurse (RN) A regarding resident 18's medication order for insulin twice a day revealed: *The EMR said to give twelve units of Novolog insulin twice a day. *The label on the plastic container holding the Novolog insulin bottle said to give ten units of insulin twice a day. The order had been written on 7/8/15. -The insulin bottle in the plastic container had been sent out by the pharmacy to the provider on 8/7/15. *The physician's orders were changed from ten to twelve units of insulin twice a day on 7/27/15. *She stated there should have been a label identifying the change placed on the label on the plastic container. *She immediately placed a label stating the order had changed over the original label. 3. Observation and interview on 8/11/15 at 11:55 a.m. with LPN D regarding resident 19's medication order for acetaminophen (Tylenol) revealed: *The EMR said to give it every six hours. *The instructions from another health care facility she had been transferred from on 3/3/15 stated to give it every six hours.	F 281	[REDACTED] * regarding the 5 rights of medication administration, inhaled medication procedures, and overall appropriate communication processes between facility and pharmacy. Beginning 9/14/2015, audits will be completed by DON or designee on resident medical records for new order implementation to match medication labels and e-mar/etar & med pass, nebulizer treatments. DON or her designee will audit five records per week for four weeks and five records per month for three months [REDACTED]. Pharmacist will continue monthly MAR audits of all residents.	

The DON or designee will take results to the next two capi meetings and then for as long as the capi meeting determines necessary

ON 9/2/15 the DON reviewed Bethany policy "Transcribing physician orders" and revised it to "transcribing and clarification of physician orders". All in-service for all nurses and medication aides will be provided by the omnicare pharmacy nurse and the DON on 9-9-15 on Bethany policy "transcribing and clarifying physician orders" and will also include training.

NP/SDOH/EL

[REDACTED]

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F 281	<p>Continued From page 3 10/17/12. *The last handwritten physician's order was dated 10/8/12, and stated to give two puffs and rinse mouth after use. *The pharmacy label on the box stated to give two puffs and to rinse mouth after use. *LPN F administered two puffs.</p> <p>7. Observation and interview on 8/12/15 at 3:00 p.m. with the director of nursing (DON) concerning resident 23's vitamin D revealed: *The EMR stated to give one vitamin D capsule every Wednesday for six weeks. *The physician's order said to give one vitamin D every week for six weeks. *The punch card from the pharmacy for August 2015 had a vitamin D tablet in the place for 8/7/15 that was a Friday, and it had not been given. There had also been one tablet in the 8/13/15 space, a Thursday. The one in 8/13/15 had been given on 8/12/15, a Wednesday.</p> <p>Interview on 8/12/15 at 3:50 p.m. with the DON, the administrator, RN F, and three staff from the consulting pharmacy per telephone revealed there was an agreement that the following should match: *The physician's order for a medication. *The instructions in the EMR on how to give the medication. *The instructions on the label from pharmacy on how to give the medication.</p> <p>A policy regarding the clarification of physicians' orders for medications was requested on 8/12/15, no policy was received by the end of the survey on 8/13/15.</p>	F 281	<p>DON, pharmacist consultant, and medical director reviewed and revised 31-dose calendar pack procedure and revised it to "Medication Administration & Return of Unused Meds". The procedure was updated with the following: Bethany nursing staff to notify pharmacy of any specific instructions (for instance: medications started in hospital/clinic/ER on certain day of week and is to continue on schedule, etc.)</p> <p><i>* All in-service for all nurses and medication aides will be provided by the DON on 9/9/15 or</i></p> <p>On 9/2/2015 the DON reviewed Bethany policy "Transcribing Physician Orders" and revised it to "Transcribing and Clarification of Physician Orders".</p> <p>An in-service for all nurses and medication aides will be provided by the Omnicare pharmacy nurse and the DON on 9-9-15 on Bethany policy "Transcribing and Clarifying Physician Orders" and will also include training</p>	<i>* NR 18004/EL</i>

Medication administration and return of unused medication NR 18004/EL

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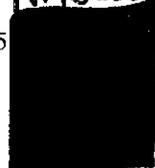
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F 281	Continued From page 4 Surveyor: 34030 B. Based on observation, interview, record review, and procedure review, the provider failed to: *Administer the full dose of a nebulizer (an inhaled medication) solution to one of one randomly observed resident (16). *Take apart, rinse, and air dry the nebulizer chamber after use for the same resident above. Findings include: 1. Observation and interview on 8/11/15 at 4:00 p.m. of registered nurse (RN) A giving resident 16 his nebulizer medication revealed: *RN A set-up and started the nebulizer treatment for the resident. *She left the room for ten minutes and then came back to stop the nebulizer. *The resident had already turned off the nebulizer machine and placed the chamber in the holder. -The chamber contained about a third of the medication solution still in it. *The resident had not received the full dose of medication. *She stated she was unsure what to do with the chamber after administering the medication, but she thought the evening staff cleaned the chambers at the end of the day. *She did not finish administering the medication nor did she take apart the chamber to rinse it and let it air dry. Review of resident 16's medical records revealed: *He had a self-administration order for medications. *He was mentally competent to do so. Review of the provider's undated procedure on	F 281	DON reviewed procedure on "Administering medications through a small volume (handheld) nebulizer" and found it to be correct. RN A personally inserviced by 9/9/2015 with return demonstration by 9/14/2015. Two additional audits of RN A to be completed by DON or her designee before 10/1/2015. Random observation of nurse administering nebulizer treatments to be completed by DON or her designee four times each month <i>[Redacted]</i> for three months. The DON or designee will take the results to the next two QAPI meetings and then for as long as the QAPI committee determines necessary. NR-ISDDOTT/EL	<i>[Redacted]</i> NR-ISDDOTT/EL

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F 281	Continued From page 5 Administering Medications through a Nebulizer revealed: *"Administer therapy until medication is gone." *"Rinse the nebulizer equipment after each use with warm water. Place on a paper towel to air dry." Interview on 8/13/15 at 8:10 a.m. with the director of nursing revealed: *She agreed the medication administration should have been completed. *The chamber had not been cleaned afterwards per their policy.	F 281	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review and interview, the provider failed to ensure restorative range of motion (ROM) had been completed as ordered for thirteen of the past thirty days for one of one sampled resident (12). Findings include: 1. Review of resident 12's medical records revealed: *A physicians' order that stated ROM exercises to be done to her right arm and leg seven days a week. *Her 7/14/15 care plan stated "Restorative therapy 7 x [times] per week PROM [passive ROM] right upper extremity [arm]/lower extremity	F 311	The medical record of Resident 12 was reviewed by ADON on 9/3/2015 and found that ROM exercises were not occurring as per instructions in care plan. Inservice training will be provided by DON to all nursing staff on 9/9/2015 about following the care plan and importance of ensuring restorative therapy as per physician order. All resident charts were audited on 9/2/2015 and it was determined that 23 residents had orders for restorative therapy. Five observation audits of restorative exercises, as well as appropriate restorative documentation, will be completed every week for the next four weeks beginning 9/14/2015 and then four per month for three months. *The DON or designee will take the results to the next two QAPI meetings and thereafter as long as the QAPI committee determines necessary.

8/9/25/15
NP/S DDCH/EL



NEED PROTECT

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F 311	Continued From page 6 [leg]." *The restorative therapy checklist showed the resident had not received ROM for thirteen of the last thirty days. Interview on 8/13/15 at 8:10 a.m. with the director of nursing revealed she had been unaware that resident 12 had not received her ROM as ordered. She agreed it should have been done as ordered. No provider policy for restorative therapy existed or was received by the time of exiting the survey.	F 311	"Rehabilitative Nursing Care" policy reviewed by DON on 9/2/2015 and revised to "Restorative Nursing Care". → ... three three months. The DON or designee will take results to the next two Quapi meetings and then for as long as the Quapi Committee determines necessary. NR/SPDOH/EL	
F 371 SS=E	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: 34030 Based on observation, interview, and policy review, the dietary supervisor and cook B failed to handle residents ready-to-eat foods in a sanitary manner for two of two observed meal services. Findings include: 1. Observation on 8/10/15 during the evening meal service revealed:	F 371	"Handling Ready to Eat Foods" policy reviewed on 9/3/2015 by Dietary Director and DON and found to be correct. Dietary director and Cook B inserviced regarding this policy by 9/9/2015 by RD. All nursing and dietary staff inserviced on this policy on 9/9/2015 by Dietary Director and DON. Dietary Director will complete random observation audits of dietary staff once weekly [redacted] DON or her designee will conduct random observation audits once weekly for [redacted] for three months. The dietary director will take the results to the next two Quapi meetings and then for as long as the Quapi Committee determines necessary. NR/SPDOH/EL	9/25/15 NR/SPDOH/EL

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F 371	<p>Continued From page 7</p> <p>*The dietary supervisor and cook B were serving hot ham and cheese sandwiches and sloppy joes. *They both had gloves on. *With their gloved hands they both: -Touched unclean surfaces such as the food cart and the outer package of buns for the sloppy joes. -Without changing gloves they handled the hot ham and cheese sandwiches and the buns and placed them onto residents meal trays to serve.</p> <p>Observation on 8/11/15 of the noon meal service revealed: *The dietary supervisor and cook B were serving turkey burgers and chipped beef with toast. *They both had gloves on. *With those gloved hands they both: -Touched unclean surfaces such as the food cart and the outer package of buns. -Without changing their gloves they would then handle the toast and buns to place onto residents meal trays.</p> <p>Interview on 8/12/15 at 2:00 p.m. with the dietary supervisor revealed he had been unaware the above glove use had not been sanitary.</p> <p>Interview on 8/13/15 at 8:10 a.m. with the director of nursing revealed she agreed the above handling of ready-to-eat foods had not been handled in a sanitary manner.</p> <p>Review of the providers 8/10/14 policy on Handling Ready to Eat Foods revealed: *"Wear gloves when handling ready to eat foods." *"Use suitable utensils when working with ready to eat foods... Those include: single user gloves, foil or paper wraps, or tongs."</p>	F 371			

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F 425 F 425 SS=E	Continued From page 8 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH 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. 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. 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. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on observation, interview, record review, policy and procedure review, the provider failed to ensure the temperatures in the refrigerators containing medications, and the freezer sections within the refrigerators were maintained in the appropriate temperature range for four of four refrigerators in all four medication storage rooms (Cottonwood Court, Maple Valley, Willow Wood Way, and Plum Creek). Findings include:	F 425 F 425		*9/15/15 NR/SDDCH/EL	

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F 425	<p>Continued From page 9</p> <p>1. Observation and record review on 8/12/15 at 2:10 p.m. in the medication storage room of Cottonwood Court, at 2:25 p.m. in Maple Valley, at 2:30 p.m. in Willow Wood Way, and at 2:35 p.m. in Plum Creek revealed:</p> <p>*The form for recording refrigerator and freezer temperatures requested:</p> <ul style="list-style-type: none"> -The temperature of the refrigerator section to have been checked and documented twice daily. -The temperature of the freezer section in the refrigerator to have been checked and documented twice daily. -The room temperature to have been checked and documented twice daily. -The time of the temperature readings was to have been documented. -The acceptable temperature range for the refrigerators was between 35 and 46 degrees Fahrenheit (F). <p>*The form was not been filled in according to the directions on the form.</p> <ul style="list-style-type: none"> -The room temperature was crossed out on two of the four temperature forms and refrigerator was written in for that area. Some refrigerator readings were in that section and some were in the section originally identified for refrigerator readings. -No freezer temperatures were written in the area identified for freezer temperatures. -There was never more than one temperature reading per day on the days a reading had been done. <p>*No readings were done on multiple days on each wing during the first twelve days of the month for August 2015 on the following:</p> <ul style="list-style-type: none"> -Cottonwood Court had four days no readings were recorded. -Maple Valley had four days no readings were recorded. 	<p>F A.</p> <p>Medication room refrigerators NR/SDDOK/EL</p> <p>36 NR/SDDOK/EL</p> <p>and immediate steps to take if the temperature is out of the acceptable range by the DON and dietary director by</p>	<p>Policy for "Maintaining Proper Refrigeration Safety" reviewed by DON and Dietary Director on 9/3/2015 and was updated to be more specific regarding temperatures for medications and food storage.</p> <p>on each resident neighborhood were inspected by director of environmental services on 8/31/2015 and found to be in working order. Temperatures were taken and thermostats were adjusted by environmental services director on 8/31/2015 to ensure normal range of 46 degrees fahrenheit. All nursing and dietary staff to be educated on the importance of documentation of the temps on the logs</p> <p>logs on each neighborhood will be audited</p> <p>9/25/15. NR/SDDOK/EL</p> <p>Medication refrigerator temperature weekly for three months. NR/SDDOK/EL</p>	<p>NR/SDDOK/EL</p> <p>The DON or designee will take the results to the next two QAPI meetings and then for as long as the QAPI committee determines necessary. NR/SDDOK/EL</p>

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F 425	<p>Continued From page 10</p> <p>-Willow Wood Way had six days no readings were recorded.</p> <p>-Plum Creek had seven days no readings were recorded.</p> <p>*Each medication refrigerator had documentation identifying its temperature went below 36 degrees F for the following:</p> <p>-Cottonwood Court was below 36 degrees F all eight times there had been a temperature documented. Four times temperatures were below freezing.</p> <p>-Maple Valley was below 36 degrees F four of eight times there had been a temperature documented. Twice the temperatures were at freezing.</p> <p>-Willow Wood Way was below 36 degrees F one time out of the six times there had been a temperature documented.</p> <p>-Plum Creek was below 36 degrees F one time out of the five times there had been temperatures documented.</p> <p>-No actions were documented as to whether something was done to bring the temperatures into the appropriate range of 36 to 46 degrees F on any of the forms.</p> <p>*Each of the refrigerators held medications, vaccines, or solutions that should not have been allowed to freeze. Included were the following:</p> <p>-Cottonwood Court had lorazepam (medication for anxiety) and three insulins.</p> <p>-Maple Valley had lorazepam.</p> <p>-Willow Wood Way had two insulins.</p> <p>-Plum Creek had lorazepam, two insulins, one eye-drop solution, two vaccines, and one tuberculosis skin test solution.</p> <p>Interview on 8/12/15 at 2:10 p.m. with the director of nurses (DON) revealed she agreed:</p> <p>*The form was not being filled out according to</p>	F 425		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2015
NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON		STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005		
(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 425	<p>Continued From page 11</p> <p>the directions.</p> <p>*There were multiple days where no temperature areas had been checked.</p> <p>*There was no documentation as to whether any attempts were made to adjust the temperature when temperatures below 36 degrees F were found.</p> <p>*The pharmacy should be called to discuss the possibility the contents within the refrigerators could have frozen during the last twelve days.</p> <p>Review of the provider's undated Maintaining Proper Refrigeration Safety policy revealed:</p> <p>*The temperature should have been maintained between 35 to 39 degrees F.</p> <p>*The thermometers were to be checked each day.</p> <p>Review of the provider's undated Medication Storage/Carts procedure revealed the refrigerated medications should have been stored between 36 to 46 degrees F.</p> <p>B. Based on observation, interview, record review, and policy review, the provider failed to ensure there was a procedure for checking physicians' medication orders were consistent with the electronic medication administration record instructions, and consistent with the instructions for administering medications from the pharmacy on labels of medication containers for 7 of 27 randomly observed medication administrations. Findings include:</p> <p>1. There was no check and balance system to ensure the physician's medication order, the instructions in the medication administration record in the computer, and the instructions supplied by the pharmacy on the medication</p>	F 425	<p>B. The physician's orders, medication label, and e-mar for residents identified were audited by Omnicare pharmacy nurse on 8/20/2015 and discrepancies will be corrected by DON or her designee by 9-9-15.</p> <p>Beginning 9/14/2015 physician's orders, medication label, and e-mar for each existing resident will be reviewed by DON or her designee for accuracy as they come due for their next scheduled quarterly care conference. Prevention of future issues will be ensured through the following process, which will take place beginning 9/9/2015: new orders will be entered by trained Bethany staff & double noted by Bethany nurse.</p> <p>On 9/2/2015 the DON reviewed Bethany policy "Transcribing Physician</p>	<p><i>* NIP 150001151</i></p> 

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2015
NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005		
(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 425	Continued From page 12 container supplied to the provider all matched. Refer to F 281, findings 1 through 7.	F 425	Orders” and revised it to “Transcribing and Clarification of Physician Orders”. An in-service for all nurses and medication aides will be provided by the Omnicare pharmacy nurse and the DON on 9-9-15 on Bethany policy “Transcribing and Clarifying Physician Orders” and will also include training regarding the 5 rights of medication administration, inhaled medication procedures, and overall appropriate communication processes between facility and pharmacy.		

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

ORIGINAL

PRINTED: 08/24/2015
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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____		(X3) DATE SURVEY COMPLETED 08/11/2015
NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON			STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 8/11/15. Bethany Home - Brandon 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 New Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

TITLE

(X6) DATE

Jane Gulickson

Administrator

9/3/15

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.

SEP 04 2015
If continuation sheet Page 1 of 1
SD DOH L&C

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10677-2	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON	STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005
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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
S 000	<p>Initial Comments</p> <p>Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 8/10/15 through 8/13/15. Bethany Home - Brandon was found in compliance.</p>	S 000		

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

Jane Gulickson

TITLE

Administrator

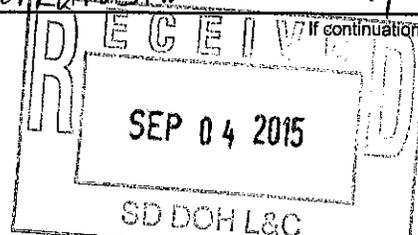
(X8) DATE

9/3/15

STATE FORM

6899

V0WG11



If continuation sheet 1 of 1