

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 12/16/2015
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 000	INITIAL COMMENTS Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/14/2015 through 12/16/2015 Bethel Lutheran Home was found not in compliance with the following requirement(s): F281, F371, F373, F441, and F465.	F 000	* Addendums noted with an asterisk per 1/26/2016 per telephone with facility administrator. NPN75DDOHL	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review, interview, and licensing board regulation review, the provider failed to follow nursing scope of practice for one of one sampled residents (14) by: *Not contacting the physician to declare death before notifying the family of the resident having no blood pressure, pulse, and respirations. *Not obtaining an order from the physician to release the deceased resident to the funeral home. Findings include: 1. Review of the medical record for resident 14 on 12/16/15 revealed at: *1:15 p.m. a nurse was notified by a certified nursing assistant (CNA) she had taken the residents vital signs (blood pressure, pulse, temperature, and respirations), and he had an elevated temperature and had been wheezing.	F 281	F 281: The facility policy and procedure titled, "Death Documentation-Notification" and the facility "Checklist to be Completed Upon the Death of a Resident" have been reviewed and revised. The revision of both forms includes insertion of the statement, "Notify the physician of the resident having no blood pressure, pulse, and respirations," so that the physician can declare death and issue an order to release the deceased resident to the funeral home. Physician notification to obtain declaration of death and an order to release the body precedes family notification of the resident's death. The Administrator met with the Medical Director on 1/4/16 and informed the Administrator/CEO of the Madison Regional Health System of this deficiency. This policy/procedure revision will be communicated to all nurses at in-service sessions that will occur on 1/8/16 through 1/13/16. The session will	

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

TITLE

ADMINISTRATOR/CEO

(X6) DATE

1/8/2016

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.

JAN 11 2016

SD DOH L&C

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F 281	<p>Continued From page 1</p> <p>*1:30 p.m. the nurse had found the resident not breathing and, he had no pulse.</p> <p>*1:40 p.m. the nurse called the resident's son, and "Informed him of his father's passing..."</p> <p>*2:35 p.m. a fax was sent to the physician and the pharmacy notifying them of the resident's death. The fax read "Res [resident] passed away at 1330 [1:30 p.m.] today."</p> <p>*3:25 p.m. there was a nurses note of "resident deceased."</p> <p>*4:20 p.m. documentation by the nurse showed the resident's body had been released to a funeral home.</p> <p>Review of resident 14's medical record revealed:</p> <p>*There was no pronouncement of death nor an order to release the body obtained from the physician by nursing staff.</p> <p>*The checklist to be completed upon death of a resident showed the order in which to complete the above necessary steps after death were:</p> <p>- "1. Family informed?"</p> <p>- "2. Physician called?"</p> <p>- 3. through 5. Were calls to various staff.</p> <p>- "6. Personal belongings accounted for?"</p> <p>- "7. Mortuary called?"</p> <p>- "8. Release of body signed by mortician?"</p> <p>Interview on 12/16/15 at 11:00 a.m. with the director of nursing revealed her expectation was nursing staff were to:</p> <p>*Notify the physician first, so death could be pronounced and obtain an order to release the resident's body.</p> <p>*Notify family the resident was deceased after the physician pronounced death.</p> <p>*Not go above their scope of practice according the to South Dakota Board of Nursing.</p>	F 281	<p>be recorded for viewing by staff unable to attend the live sessions. The MDS Coordinator will review all discharge files monthly to determine 1) Physician notification to declare death prior to family notification; and 2) Obtaining an order from the physician to release the deceased resident to the funeral home. The MDS Coordinator will present her findings to the Director of Nursing monthly. The Director of Nursing will present a report to the Quality Assurance (QA) Committee at their quarterly meeting <i>* for one year from survey date.</i></p> <p><i>NPN/SDDOH/EL</i></p>	1/13/16

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F 281	Continued From page 2 Review of the South Dakota Board of Nursing memo dated August 4, 2014, regarding pronouncement of death by nursing staff revealed "Legal counsel for the Board of Nursing advised the Board, at their January 1994 Board Meeting, that the Legislature's intent of SDCL 34-25-18 and 34-25-18.1 were to designate the signing of the death certificate as a medical act by a physician, physician's assistant, or nurse practitioner. Since the Legislature did not provide that the act is delegable to any one else, the Board does not believe a licensed nurse can officially pronounce death." There was no policy provided to this surveyor prior to exit of the survey regarding death of a resident.	F 281			
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: 32331 Based on observation, interview, and policy review, the provider failed to: *Follow appropriate handwashing for four of four randomly observed employees (H, I, J, and K) in	F 371	F 371: 1. The facility policy for handwashing/hand hygiene has been reviewed by the Certified Dietary Manager (CDM) and Registered Dietitian (RD). A mandatory handwashing in-service was held on 1/7/16 for all food service staff. The in-service included examples of situations when hands are contaminated and handwashing is indicated. More specifically, staff members were instructed on proper handwashing opportunities, which include hand washing upon entering the kitchen after obtaining items from the dry storage area and from the walk-in cooler/freezer areas. Specific instructions on the proper handwashing technique were		

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F 371	<p>Continued From page 3</p> <p>the kitchen during two of two observed meals. *Ensure sanitary condition was maintained for one of one fan that had not been cleaned in the kitchen's walk-in refrigerator. Findings include:</p> <p>1. Observation on 12/14/15 from 5:45 p.m. through 5:55 p.m. during the evening meal service in the kitchen revealed: *Dietary assistant J: -Left the kitchen to go to the dry goods storeroom. -That storeroom was located outside the kitchen through a closed kitchen door, a service hallway, and a closed door marked "Dietary Storage." -She returned to the kitchen with a can of soup, opened the soup with her ungloved hand, opened a cupboard door, obtained a bowl from that cupboard, closed that cupboard door, put the soup into the bowl, opened the microwave, and placed the soup inside, and turned on the microwave. -She then started making bacon-lettuce-tomato (BLT) sandwiches. -She removed the soup from the microwave, had the temperature taken by cook H, and placed it back in the microwave. -She then opened the refrigerator and removed a tray of egg salad sandwiches. -She removed the soup from the microwave and placed it on a tray for an unidentified resident. -She reopened the refrigerator, removed an ice cream container from the freezer section, removed the top of the container, and gave it to an unidentified staff person for an unidentified resident. -She returned to making BLT sandwiches. -She reopened the refrigerator door and obtained a cottage cheese container.</p>	F 371	<p>demonstrated with handouts provided to staff. In addition to handwashing guidelines, new procedures are in place to help reduce the number of additional tasks the cooks may encounter during meal service. For example, staff will set up a container of frequently requested items (ice cream, cottage cheese, etc.) prior to meal service, to be kept on ice so they remain cold during meal service. The CDM and/or RD will monitor handwashing procedures and the amount of cook tasks that occur away from the meal service area (which the cook would then prepare/complete during meal service) to ensure that the new procedures are being followed and to reduce the amount of tasks which take the cooks away from the meal service. This QA will be monitored at least once weekly at alternate times for 3 months. The CDM will report the QA results at the quarterly QA meetings.</p> <p>2. Staff will continue to serve meal service with ungloved hands, as appropriate, to avoid overuse of gloves when using utensils and dishing food. Proper handwashing will occur as indicated between cook tasks (and as was instructed per handwashing in-service provided on 1/7/16).</p>	

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F 371	<p>Continued From page 4</p> <p>-She returned to making BLT sandwiches. -She reopened the refrigerator and removed an ice cream container from the freezer section, removed the container's top, and gave it to an unidentified staff person for an unidentified resident. -At no time during the observed observation did she wash her hands. -At 5:55 p.m. she washed her hands for less than ten seconds. *Employees were to have scrubbed for a minimum of ten to fifteen seconds within the twenty-second hand washing procedure.</p> <p>2. Observation on 12/14/15 from 6:14 p.m. through 6:16 p.m. during the evening meal service in the kitchen revealed: *Cook H: -With ungloved hands was serving the evening meal service. -Opened the refrigerator and obtained a package of cheese. -Then opened a drawer with her ungloved hand and removed a utensil. -Using that above utensil she placed the cheese on a plate and served an unidentified resident. -Then wiped her nose on her sleeve and touched her shirt with her hand. -She continued to dish foods on plates for the residents. -At no time during the above observation did she wash her hands.</p> <p>3. Observation on 12/15/15 from 12:03 p.m. through 12:12 p.m. during the noon meal service in the kitchen revealed: *Cook I: -With ungloved hands was serving the noon meal.</p>	F 371	<p>3. Staff will continue to serve meal service with ungloved hands, as appropriate, to avoid overuse of gloves when using utensils to dish food. Proper handwashing techniques will be used as indicated between cook tasks.</p> <p>4. Proper handwashing techniques will be used by all foodservice staff as indicated by the facility handwashing/hand hygiene policy.</p> <p>5. The Maintenance Supervisor cleaned the fan cover and blades identified in the survey on 12/17/15. The Maintenance Supervisor has also written a new cleaning schedule which requires the fan cover and fan blades to be cleaned quarterly (or more frequently if needed) rather than annually. The cleaning will be documented by the Maintenance Supervisor, and he will report this at the quarterly Quality Assurance meetings. It should be noted that the fan was blowing over food being stored in the walk-in cooler, but that the food being stored was covered, labeled and dated.</p> <p><i>*for one year from survey date of 12/17/15. NPN/SDDOTTIEL</i></p>	1/20/16

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F 371	<p>Continued From page 5</p> <ul style="list-style-type: none"> -She opened the refrigerator and obtained a gallon container of milk and gave it to an unidentified staff person. -She returned to picking up plates and serving food to residents from the steam table. -Then opened a cupboard and removed a container of cornflakes, obtained a bowl, and poured the cereal into a container, and served it to an unidentified resident. -She continued to serve on the trayline. -At no time during the above observation did she wash her hands. <p>4. Observation and interview on 12/15/15 at 12:12 p.m. with cook K in the kitchen revealed she:</p> <ul style="list-style-type: none"> *Had come into the kitchen and put on a new pair of gloves. *Had gloves on started to work with resident food on the food preparation counter. *At no time during the above observation did she wash her hands. *Stated she had been to the dry foods storeroom. -That storeroom was located outside the kitchen through a closed kitchen door, a service hallway, and a closed door marked "Dietary Storage." *Was unaware she had needed to have washed her hands before putting on the gloves. <p>Interview on 12/15/15 at 4:50 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> *Hands were to have been washed for at total of twenty seconds. *She expected hands to have been cleaned when coming into the kitchen from a hallway, after touching cupboards, drawers, and contaminated equipment. <p>Interview on 12/16/15 at 11:00 a.m. with the certified dietary manager (CDM) confirmed:</p>	F 371		

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F 371	<p>Continued From page 6</p> <p>*Hands were to have been washed before putting gloves on.</p> <p>*Hands were to have been washed for at least twenty seconds.</p> <p>*Hand hygiene procedures were to have been followed.</p> <p>Review of the provider's 2013 Handwashing policy revealed:</p> <p>*Staff were to have washed hands as frequently as needed throughout the day following proper handwashing procedures.</p> <p>*When to wash hands:</p> <ul style="list-style-type: none"> -After touching bare human body parts other than cleaned hands and cleaned, exposed portions of arms. -After handling soiled equipment or utensils. -During food preparation, as often as necessary to remove soil and contamination, and to prevent cross-contamination when changing tasks. -Before putting on gloves for working with food. -After engaging in other activities that contaminate the hands. <p>*How to wash hands had included:</p> <ul style="list-style-type: none"> -Scrub for a minimum of ten to fifteen seconds within the twenty second handwashing procedure. <p>Review of the provider's 11/18/15 Handwashing/Hand Hygiene policy revealed the provider considered hand hygiene the primary means to prevent the spread of infections.</p> <p>5. Observation on 12/14/15 from 2:10 p.m. through 2:50 p.m. of the kitchen revealed:</p> <ul style="list-style-type: none"> *The Bohn fan cover on the blades in the walk-in refrigerator in the kitchen contained a moderate build-up of brown, gray, and black spots on it. *The above fan was blowing over food that was being stored there. 	F 371		

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F 371	Continued From page 7 Interview on 12/16/15 at 11:00 a.m. with the maintenance director and the CDM in the kitchen revealed: *The maintenance director stated his department was responsible for cleaning the refrigeration unit fan. *The maintenance director stated he had the fan in the walk-in refrigerator on a yearly cleaning schedule. -That above fan had last been cleaned in June 2015. -He stated he had not kept a cleaning schedule with documentation of that above cleaning. -He stated he did not have a policy and procedure for cleaning that fan. *Both agreed the fan in the walk-in refrigerator needed to have been cleaned.	F 371			
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant	F 373	<p>→ *(dining assistant, nursing assistant, certified nurse assistant, or nurse.) NPN/SDDO/H/EL</p> <p>→ *Residents who have complicated feeding problems will be fed by a CNA or nurse. NPN/SDDO/H/EL</p> <p>F 373: Resident 9 is being assisted/fed in the dining room by a Certified Nursing Assistant (CNA). The cue card for Resident 9's feeding program has been placed at his table. Residents requiring feeding will be reviewed by the Registered Dietitian (or designee), Director of Nursing (or designee), and Charge Nurse at the weekly skin/hydration meeting to insure "qualified staff" are being utilized to assist residents requiring feeding. The Dining Assistant job description will be reviewed with nurses at in-service sessions that will occur on 1/8/16 through 1/13/16. The session will be recorded for viewing by staff unable to</p>		

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F 373	<p>Continued From page 8</p> <p>feeds only residents who have no complicated feeding problems.</p> <p>Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.</p> <p>The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care.</p> <p>NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:</p> <ul style="list-style-type: none"> o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: <ul style="list-style-type: none"> Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. <p>A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.</p>	F 373	<p>attend the live sessions. The day and evening shift charge nurses will conduct a monthly QA on residents requiring feeding to determine appropriate staff assignment as well as proper placement of cue cards, when indicated. They will present their findings to the Director of Nursing monthly. The Director of Nursing will present a report to the QA Committee at their quarterly meeting <i>for</i> 1/13/16 <i>one year from the survey date.</i> <i>NPN/SDDO#EL</i></p>

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F 373	Continued From page 9 This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Surveyor: 32331 Based on observation, record review, interview, job descriptions, program review, and policy review, the provider failed to ensure qualified staff were used to assist one of one sampled resident (9) who had swallowing precautions. Findings include: Surveyor: 29354 1. Observation and interview on 12/15/15 at 8:15 a.m. in the dining room revealed: *Care team technician (CTT) E had been feeding resident 9. *Interview at the above time with registered nurse (RN) L regarding resident 9 and CTT E revealed: -CTT E was a dining assistant and usually fed resident 9. -CTT E was not a certified nursing assistant (CNA). -Resident 9 had been declining over the past three weeks. -The speech therapist: -Had been working with him due to a swallowing problem. -Had attempted interventions by using a neck pillow and "rock and go" wheelchair. Surveyor: 32331 Observation and interview on 12/15/15 at 8:30 a.m. and CTT E with resident 9 in the dining room revealed: *He was seated in a wheelchair at a supervised eating table. *CTT E was assisting him with eating	F 373			

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F 373	<p>Continued From page 10</p> <p>*CTT E stated he was a challenge as he had a swallowing problem.</p> <p>Observation on 12/15/15 at 12:25 p.m. and on 12/16/15 at 8:00 a.m. in the dining room revealed CTT E was assisting resident 9 with eating.</p> <p>Review of resident 9's 10/6/15 by SLP (speech language pathologist) G Swallowing Precautions instructions sheet revealed he needed to have:</p> <ul style="list-style-type: none"> *Supervision/monitoring during all oral intake by trained staff. *Sat up with hips flexed at ninety degrees for all oral intake. *Tilted chin down or at least in neutral position to swallow with every bite of food and sip of liquid. *Sat up with hips flexed at ninety degrees for thirty minutes following meals. *Taken small bites, sips of fluid, and needed monitoring. *At least two swallows per bite of food and sip of liquid. *No straws. *No thin liquids (including water). *Medications in applesauce. *Alternate bites of solid with sips of liquid. *Recommended cup that controls amount of flow. <p>Review of resident 9's 10/28/15 quarterly Minimum Data Set (MDS) section K assessment revealed he had coughing or choking during meals or when swallowing medications</p> <p>Review of resident 9's revised 11/3/15 care plan revealed:</p> <ul style="list-style-type: none"> *"Resident will be assisted by staff. *Resident will use plate guard, cut out cup, clothing protector, and a weight on wrist to assist with eating his meals. 	F 373		

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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 12/16/2015
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 373	<p>Continued From page 11</p> <p>*Sits with neck hyperextended [movement beyond the normal limit] use cueing [to assist in the completion of a task by offering prompts] and encourage to tuck chin when eating or move plate to promote independence."</p> <p>Review of resident 9's medical record revealed: *He had a diagnosis of dysphagia (difficulty swallowing). *His physician's 11/10/15 diet order consisted of a regular diet with NDD (National Dysphasia Diet) II (level two) texture with nectar consistency liquids. *Progress notes on 11/6/15 by SLP G revealed: -He needed reminders to take small bites and to do double swallows. -He needed reminders to take one drink at a time, to keep chin down, and not to extend head back. He had a "slight gurgly voice 2xs [two times] during the session when he did gulp swallows." *Progress notes on 11/10/15 by SLP G revealed: -He needed moderate cueing to follow swallowing techniques during his meal. -He needed reminders to do double swallows. -He had one coughing spell when he had ignored the cue to do double swallows. -He had swallowing precautions at his chair side and in the communication book. *Progress notes on 11/12/15 by SLP G revealed: -He needed to continue cues to take small to medium sized drinks. -He was following swallowing techniques with cues. -Staff had a copy of swallowing techniques to cue him with his meals. *A 11/12/15 SLP G evaluation had indicated: -Staff were to have assisted in following swallowing precautions. -He had needed moderate to maximum cues for following swallowing precautions and techniques.</p>	F 373		

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F 373	<p>Continued From page 12</p> <p>-He was to have remained on nectar liquids, as he became "gurgly" on thin liquids.</p> <p>-Staff had a copy of swallowing precautions to follow when assisting at meals.</p> <p>Interview on 12/15/15 at 2:30 p.m. with RN F revealed:</p> <p>*She was responsible for directing the provider's dining assistant program.</p> <p>*The provider had an approved dining assistant program since 12/19/02.</p> <p>*A CTT could assist residents with eating difficulties.</p> <p>*CTT E had gone through the dining assistant program as had all CTT staff in the facility.</p> <p>*A CTT was not a CNA or a licensed nurse.</p> <p>*Resident 9 had a "harder time with swallowing."</p> <p>-Information regarding his swallowing techniques was in the CNAs' communication book.</p> <p>-That information was also located on his table in the dining room during meals.</p> <p>*She agreed resident 9 had a complicated feeding program.</p> <p>Interview on 12/15/15 at 3:45 p.m. with the consultant registered dietitian (RD) regarding resident 9 revealed she agreed he had a complicated feeding program.</p> <p>Observation and interview on 12/16/15 at 8:20 a.m. with CTT E in the dining room regarding resident 9's swallowing precautions program revealed:</p> <p>*She had been using a card to follow his feeding program that was to have been located in the dining room at his table.</p> <p>-That above card was not located at his table.</p> <p>-She was unsure of where it was.</p>	F 373			

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F 373	<p>Continued From page 13</p> <p>Interview on 12/16/15 at 8:45 a.m. with SLP G via the telephone regarding resident 9 revealed: *He was a more challenging and complicated "feeder." *Information regarding his swallowing techniques was to have been located at his dining room table and in the communication book.</p> <p>Interview on 12/16/15 at 10:10 a.m. with the assistant director of nursing and RN D regarding resident 9 reviewed: *The charge nurse had made the call on which staff had been feeding the residents. *Both agreed resident 9 was a complicated feeder. *Both confirmed CTT E was not a CNA nor a licensed nurse.</p> <p>Review of the provider's Assisted Dining Program for CTT E revealed she had completed the program on 11/12/10.</p> <p>Review of the provider's undated Dining Assistant job description revealed: *"A dining assistant may only feed a resident who does not have a complicated feeding problem. *A dining assistant cannot feed a resident who has complicated feeding problems or clinical conditions that require nursing training in order to be fed safely."</p> <p>Review of the provider's undated CTT job description revealed nursing service functions, if trained as a dining assistant, had included to have assisted residents to consume nourishment/fluids at snack and mealtime.</p> <p>Review of the provider's 12/15/15 Dining Assistance policy revealed:</p>	F 373		

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F 373	Continued From page 14 *A dining assistant may have taken, prepared, and served food to a resident at meal time. *A dining assistant may only have fed a resident who did not have a complicated feeding program. *The charge nurse in consultation with the director of nursing (DON), assistant DON or designee, or the RD may alter dining assignments based on resident's needs and conditions. Review of the provider's 2003 Assisted Dining: The Role and Skills of Feeding Assistants program used for training dining assistants revealed: *A feeding assistant could not have fed a resident who had complicated feeding programs or clinical conditions that required nursing training in order to be fed safely. *An example of those conditions had included difficulty swallowing.	F 373			
F 441 SS=D	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.	F 441	F 441: The facility policy and procedure for Handwashing/Hand Hygiene/Glove Use will be reviewed/revised by the Infection Control Nurse and the Director of Nursing. In-service training on handwashing, hand hygiene, and applying and removing gloves will be presented 1/8/16 through 1/13/16 to all staff responsible for the assigned task. Surveyor observations in Resident 8 and Resident 16's rooms will be included in the presentation. The sessions will be recorded for viewing by staff unable to attend the live sessions. The Infection Control Nurse and the Director of Nursing will serve as presenters.		

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F 441	<p>Continued From page 15</p> <p>(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 isolate the resident. (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. (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: 29354 Based on observation, interview, and policy review, the provider failed to ensure hand hygiene was performed during residents' personal care for two of three observed residents (8 and 16) by two of three observed staff (A and B). Findings include:</p> <p>1. Observation on 12/15/15 at 9:01 a.m. in resident 8's room revealed: *Certified nursing assistant (CNA) A and nursing assistant (NA) B entered his room. Without performing hand hygiene or putting on gloves: *They transferred the resident from the "rock and go" wheelchair with a mechanical lift (equipment</p>	F 441	<p>The Infection Control Nurse (or designee) will conduct QAs on handwashing/hand hygiene and glove use weekly for one month, bi-weekly for two months, and monthly thereafter. She will present her findings to the Director of Nursing. The Infection Control Nurse (or designee) will present a report to the QA Committee at their quarterly meeting.</p>	1/13/16	

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F 441	<p>Continued From page 16</p> <p>used for moving a resident) to his bed. *After repositioning him in bed: -CNA A took her bare right hand and partially pulled the resident's slacks down. With that same bare hand she felt his protective brief. -They removed the mechanical lift sling from under the resident. -NA B left the room. *CNA A pushed the mechanical lift with her bare hands out of the room, down the hall way, and into resident 16's room. -She had not performed any type of hand hygiene. -She had not disinfected the mechanical lift before taking it into another resident's room.</p> <p>2. Observation on 12/15/15 at 9:15 a.m. in resident 16's room revealed: *CNA A and the assistant director of nursing (ADON) were in the resident's room. Without performing hand hygiene they: -Transferred the resident from the wheelchair with a mechanical lift to the bed. -CNA A and the ADON put on gloves. -CNA A left the room. She returned with a spray bottle and a few cloths. *They: -Repositioned the resident in bed. -Pulled the resident's slacks down. -Removed the incontinent brief. -Repositioned the resident to her left side. -CNA A then wiped the resident's buttock and coccyx (tail bone) area. -Pulled up the resident's slacks. *With the same gloved hands CNA A: -Took the bed control and raised the bed. -Gave the resident a drink of water. -Took the radio from her pocket and answered a call.</p>	F 441			

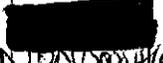
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F 441	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Put the radio back into her pocket. -Removed her gloves and then washed her hands. <p>Interview on 12/15/15 at 5:00 p.m. with the infection control nurse revealed:</p> <ul style="list-style-type: none"> *Her expectations would have been for the staff: <ul style="list-style-type: none"> -To wash their hands. -Clean the mechanical lift between each resident use. *Reeducate the CNA during the above event. <p>Interview on 12/15/15 at 5:51 p.m. with the director of nursing revealed her expectations would have been for the staff to wash their hands.</p> <p>Review of the provider's 11/18/15 Handwashing/Hand Hygiene policy revealed:</p> <ul style="list-style-type: none"> **The facility considers hand hygiene the primary means to prevent the spread of infection. *Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: <ul style="list-style-type: none"> -Before and after direct contact with residents. -Before handling moving from a contaminated body site to a clean body site during resident care. -After contact with a resident's intact skin. -After contact with bodily fluids. -After removing gloves. *Single-use disposable gloves should be used when anticipating contact with blood or body fluids." <p>Review of the provider's revised July 2012 Incontinence Care policy revealed:</p> <ul style="list-style-type: none"> **Incontinence care is provided to insure 	F 441			

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F 441	Continued From page 18 adequate skin care in order to prevent skin breakdown. *Equipment needed: Gloves. *Procedure: Apply gloves."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation and interview, the provider failed to ensure ceiling tiles were replaced when soiled or stained in three of three halls and in one of one front dayroom. Findings include: 1. Observation and interview on 12/15/15 at 2:30 p.m. during a walk-through of the facility revealed: *The south hall had three ceiling tiles around the air vents that had visible water stains and a black mold-like substance surrounding the air vent. -That had been caused by a water leak earlier that summer. -Maintenance staff had not had time to replace the tiles yet. *Three tiles in the front dayroom had visible water stains around the air vents. *The west hall had four visibly water stained tiles around the air vents. *The north hall had three visibly water stained tiles surrounding the camera and the air vent. *He believed all of the stains except in the south hall had been caused by condensation from the	F 465	F 465: The Maintenance Supervisor and staff have replaced the specific tiles that were identified during the survey. The full survey report and plans of correction are on the agenda for the 1/25/16 Board of Directors meeting. The Administrator will ask the Building Committee to consider a phased-in plan which would call for replacing all of the existing ceiling tiles in each neighborhood. A new housekeeping cleaning schedule for the acoustical tiles has been written which will require all tiles to be vacuumed quarterly and documented by the Housekeeping/Laundry Supervisor, who will report the results at the quarterly QA Committee meeting. Any acoustical tiles that are stained will be replaced by the Maintenance personnel as needed. This will be reported by the Maintenance Supervisor at the quarterly QA meeting. The facility did have a commercial roofing company go over the facility roof in May and June of 2015 to seal the few areas where water stains had been noted on the tiles. The company also examined the entire roofing area for the building at that time.	<i>*NPN/SDD/H/EC</i>  <i>*for one year from the survey date, the maintenance supervisor has added this to the facility preventative maintenance schedule. NPN/SDD/H/EC</i> 

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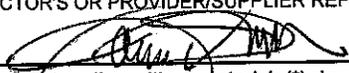
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F 465	Continued From page 19 roof earlier that summer. *He agreed those tiles needed to be replaced. There was no policy provided to this surveyor on maintenance of the building at the time of this survey nor by the exit of survey.	F 465		*2/4/16 NPN/DDD/H/EL	

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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 12/15/2015
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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 12/15/15. 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		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE **ADMINISTRATOR/CEO** (X6) DATE **1/8/2016**

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.

JAN 11 2016
SD DOH L&C

South Dakota Department of Health

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 12/16/2015
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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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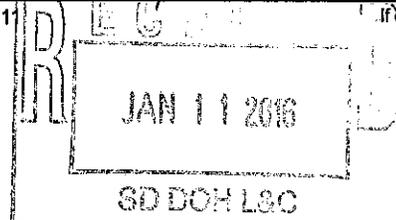
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/14/15 through 12/16/15. Bethel Lutheran Home was found not in compliance with the following requirement(s): S237.</p>	S 000	<p><i>*Addendums noted with an asterisk per 1/26/2016 per telephone with facility administrator. NPN/SDDOHL</i></p>	
S 237	<p>44:73:04:12(2) Tuberculin Screening Requirements</p> <p>Tuberculin screening requirements for healthcare workers or residents are as follows: (2) A new healthcare worker or resident who provides documentation of a positive reaction to the tuberculin skin test or TB blood assay test shall have a medical evaluation and chest X-ray to determine the presence or absence of the active disease; and</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure one of five sampled employees (C) with a past history of a positive reaction to the Mantoux tuberculosis (TB) skin test had received a medical examination and a chest x-ray upon being hired. Findings include:</p> <p>1. Review on 12/16/15 of employee C's personnel file revealed: *A 8/12/15 hired date. *A one-step TB skin test dated 8/12/15 revealed she was a positive reactor. *She had documentation of a physician's review and a chest x-ray on 4/19/04. *There was no evidence she had a medical evaluation and chest x-ray to determine the</p>	S 237	<p>S 237: Employee C has scheduled an appointment on 1/11/16 at 3:30pm for a chest x-ray, followed by a clinic appointment with a provider to "determine the presence or absence of the active disease." The results of this chest x-ray will be shared with the Infection Control Nurse, the Director of Nursing, and the Assistant Administrator, and a copy of the results will be placed in the employee's personnel file in the Business Office.</p> <p>If the x-ray is negative and shows that the employee does not have TB, the employee will be allowed to continue working as normal. If the x-ray is positive and shows that the employee does have TB, she will be removed from the floor until treatment is completed. This employee will have an annual health screening to determine whether signs/symptoms of TB are present, which would require additional chest x-rays and medical examination.</p> <p>All new employees are tracked by Administration, through the Assistant Administrator, to see that the TB</p>	

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

TITLE

Administrator/CEO

(X6) DATE
1/8/2016



South Dakota Department of Health

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 12/16/2015
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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**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 237	<p>Continued From page 1</p> <p>presence or absence of the active disease upon having been hired.</p> <p>Interview on 12/16/15 at 10:20 a.m. with the assistant director of nursing revealed: *She confirmed employee C had not had a medical evaluation and chest x-ray after the results of the one-step positive TB skin test on 8/12/15. *She agreed the provider had not followed their policy and procedure for employee C.</p> <p>Review of the provider's February 2015 Tuberculin (TB) Screening Requirements revealed: *Any new employee who had provided documentation of a previous reaction of the TB skin test was to have had a medical evaluation and a chest x-ray. *The medical evaluation and a chest x-ray were to have determined the presence or absence of the active disease.</p>	S 237	<p>screening requirements are met by the facility.</p> <p>Employees who react positively to the TB testing will be required to have a chest x-ray and medical examination. They will not be scheduled to work until the results of the x-ray and medical exam have been provided to the facility business office. They will also receive an annual health assessment to determine whether signs/symptoms of TB are present.</p> <p>The Assistant Administrator or her designee will report quarterly to the QA Committee on the number of employees hired in the quarter, and the facility compliance with this standard during the quarter.</p> <p><i>NPN/SDOAH/EL</i> *The infection control nurse (or designee) will assess more frequently, as needed, any positive reactors to the TB test. The assessment will consist of the nurse meeting with the employee and having them complete a mini assessment to determine the prevalence of any of the following symptoms: weight loss, fever, night sweats, coughing up blood, fatigue, persistent cough, recurrent colds or chest pain. The prevalence of any of these symptoms will result</p>	1/11/16
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