

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

ORIGINAL

PRINTED: 06/22/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105
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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 6/7/16 through 6/9/16. Bethany Home Sioux Falls was found not in compliance with the following requirements: F157, F176, F280, F281, F323, F387, F431, and F514.	F 000	*Addendums noted with an asterisk per 7/1/16 per telephone with facility administrator. NPN/SPD/HJL	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Suozzi</i>	TITLE <i>Administrator</i>	(X6) DATE <i>7/1/2016</i>
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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 157	Continued From page 1 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to notify the physician or hospice services for one of one sampled resident (8) who was refusing her medications. Findings include: 1. Review of resident 8's medical record revealed: *She was admitted on 4/13/16 and enrolled in hospice on 4/18/16. *The April 2016 medication administration record (MAR) revealed: -It was marked she had spit out her medications ten times. -The spit out medications included those for pain and disruptive behaviors. *The May 2016 MAR revealed: -It was marked she had spit out her medications thirty-one times. -The spit out medications included those for pain and disruptive behaviors. *The 6/1/16 through 6/8/16 MAR revealed: -It was marked she had spit out her medications twenty-six times. -It was marked she had refused her medications nine times. -The refused or spit out medications included those for pain and disruptive behaviors. *There was no documentation the physician or	F 157	The DON reviewed resident 8 MAR on 6/27/16 and noted that resident 8 continues to spit out and/or refuse her medications on an intermittent basis. On 6/27/2016 the DON ensured notification of physician and documentation of physician's response regarding resident 8 medication refusal. On 6/27/2016 the DON created a new policy titled "Refusal of Treatment" which includes direction to contact the physician and document physician response should the resident refuses to take medication as prescribed. The DON will complete a personal in-service with LPN C by 7/1/2016 over the "Refusal of Treatment" policy to ensure her understanding of the need to contact physician and to document response when a resident refuses medication. The DON will provide an in-service on this policy on 7/7/2016 for all Bethany nurses and medication aides. The DON and Nurse Managers will review all resident MARs to identify any other residents who may have refused medications to ensure physician notification by 7/29/2016. Beginning 7/29/2016 the DON or her designee will conduct an audit of all MARs to ensure physician notification and documentation of response in the event of a resident refusing medication. Audits will be conducted by the DON or her designee weekly for four weeks and then monthly thereafter. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.	7/29/2016	

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F 157	Continued From page 2 hospice agency had been notified of her spitting out or refusing her medications until 6/8/16. Interview on 6/9/16 at 9:00 a.m. with the director of nursing revealed: *She was unaware if staff had notified the physician or the hospice agency prior to 6/8/16. *It was her expectation the staff would notify the hospice agency if the resident was spitting out or refusing medications. Interview on 6/9/16 at 10:30 a.m. with licensed practical nurse C regarding resident 8 refusing her medications revealed she would: *Re-approach the resident with the medications a short time after her initial refusal. *Chart on the MAR and enter a progress note if not successful. *Pass along the information to other nursing staff in report. *Not call the hospice agency or physician if it was an isolated occurrence. Review of the provider's 5/7/14 Protocol for Notification of a Physician policy revealed it did not address how the refusal of medications should be handled.	F 157		
F 176 SS=E	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by:	F 176		

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F 176	<p>Continued From page 3</p> <p>Surveyor: 36413 Surveyor 33488</p> <p>Based on observation, interview, record review, and policy review, the provider failed to perform medication self-administration assessments on 6 of 13 (2, 3, 6, 9, 10, and 13). Findings include:</p> <ol style="list-style-type: none"> 1. Observation on 6/7/16 at 11:07 a.m. of resident 3's room revealed his prescription medication barrier cream (used for skin protection), had been left on his dresser. 2. Observation on 6/7/16 at 11:10 a.m. of resident 2's room revealed his prescription medication barrier cream had been left on his dresser. 3. Observation and interview on 6/7/16 from 3:30 p.m. through 4:10 p.m. with resident 13 during a breathing medication treatment revealed: *Licensed practical nurse (LPN) E entered the room and examined the resident. *She then administered the breathing treatment to the resident and left the room and had not returned. *At 4:10 p.m. the resident had turned off the breathing treatment and set it on her bedside tray. *She stated staff lets her do that "Because they figure I can do it myself." <p>Surveyor 36413</p> <ol style="list-style-type: none"> 4. Observation on 6/7/16 at 5:50 p.m. with resident 10 revealed his medications were on his dinner tray. He took them without direct staff observation. *Staff continued to pass other residents medication and let him take the medication when he preferred without staff direct observation. 	F 176	<p>The DON confirmed on 6/28/16 that prescription barrier creams were removed from residents 2, 3, 6, 9, 10, and 13 rooms. Resident 9 insisted on keeping medications at bedside. On 6/28/2016 a Self-Administration Assessment and Cognitive Assessment was completed on resident 9 by the DON and a physician order for self-administration was received on 7/1/2016.</p> <p>On 6/28/2016 the DON determined that a Self-Administration Assessment need not be completed on resident 13 due to resident not being deemed safe to self-administer and the need for nursing assessment before and after administration of nebulizer. On 6/28/16 the DON reviewed both the "Self-Administration" and "Medication Administration" policies and found both to be correct. The DON will complete a personal in-service with LPN E, and RN F to review the survey findings as well as review the "Self-Administration" policy by 7/1/2016 to ensure understanding of the need for assessment prior to allowing a resident to self-administer medications.</p>	7/29/2016	

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F 176	<p>Continued From page 4</p> <p>Review of resident 10's medical record revealed: *He did not have a physician's order to take his own medication. *He did not have a self-administration assessment on his chart.</p> <p>5. Interview on 6/7/16 at 6:30 p.m. with certified medical assistant (CMA) D revealed: *She was not aware if any residents had self administration assessments. *She had been trained to leave medications with some residents, and they would take their meds on their own.</p> <p>Surveyor 33488</p> <p>6. Observation and interview on 6/8/16 at 1:40 p.m. with registered nurse (RN) F while in resident 13's room revealed: *Calmoseptine ointment (prescription barrier cream) had been left unattended on the sink. *Staff and the resident applied it to the resident's skin when needed. *RN F was unaware of any resident in the facility having a self-administration order for medication administration.</p> <p>Surveyor 36413</p> <p>7. Observation and interview on 6/8/16 at 2:30 p.m. in resident's 9 room revealed: *She had Nystop powder (a prescription powder) at her bedside. *She stated she put it on as needed in the folds of her skin to prevent skin breakdown.</p> <p>8. Observation on 6/8/16 at 3:30 p.m. in resident 6's room revealed a tube of prescription cream was on her bedside table.</p> <p>Surveyor 33488</p>	F 176	<p>The DON will provide a personal in-service with CMA D on both the "Self-Administration" and "Medication Administration" policies by 7/1/2016 to ensure understanding of proper medication administration procedures as well as a need for self-administration order prior to leaving a resident with medication to self-medicate. On 7/7/2016, the DON will provide an in-service regarding the survey findings and to review both the "Self-Administration" and "Medication Administration" policies with all Bethany nursing staff. The DON and Nurse Managers will review all residents in order to identify any other residents who may have a need for a "Self-Administration" order and assessment by 7/29/2016. Beginning 7/29/2016 the DON or her designee will conduct two random med pass audits per week for four weeks and then monthly thereafter to ensure that medications are administered per the "Medication Administration" policy and to ensure that any meds left for resident to self-administer are supported by proof of documentation of an order and assessment for self-administration of medications. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p>		

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F 176	<p>Continued From page 5</p> <p>9. Interview on 6/9/16 at 10:20 a.m. with the director of nursing (DON) regarding the above observations and residents revealed she agreed those:</p> <ul style="list-style-type: none"> *Residents had been left by themselves to finish medication administration. *Medications were being left at the residents' bedside for self-administration or the potential staff assist if needed or offered. *There were no residents at the time of the survey with orders for self-administration of medications in the facility that she had been aware of. *She agreed leaving medications in a room for residents to administer was self-administration. *Residents should have been assessed to safely self-administer medications initially, quarterly, and as part of an ongoing assessment. <p>Surveyor 36413</p> <p>Interview on 6/9/16 at 11:30 a.m. with the DON revealed she was not aware the person giving medications did not observe the medications being taken.</p> <ul style="list-style-type: none"> *She was not aware the person giving medications would begin another task or leave the room before the resident had taken the medication. <p>Review of the provider's 9/14/12 Self-Administration of Medications policy revealed:</p> <ul style="list-style-type: none"> *A physician's order to allowing a resident to keep medications at the bedside was to have been obtained. *An assessment was to have been performed initially, quarterly, and ongoing. *All residents who self administer medications were to have been reviewed on a quarterly basis 	F 176		
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F 176	Continued From page 6 by the DON and care managers and findings sent to the quality committee for review.	F 176		
F 280 SS=D	<p>Surveyor: 33488 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on interview, record review, and policy review, the provider failed to update the care plan for one of one sampled resident (3) after returning from the hospital. Findings include:</p>	F 280		

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F 280	<p>Continued From page 7</p> <p>1. Review of the medical record and current care plan for resident 3 revealed: *His admission date was 1/7/16. *He had a history of a stroke and he received Plavix and an aspirin (used as "blood thinners"), prior to his hospitalization. *No mention of the resident's recent hospitalization for a blood clot. *No bleeding precautions were documented on his care plan. *The physician's orders for a laboratory blood test, called a prothrombin time/international normalized ratio (PT/INR) had not been transcribed into his physicians' orders section of his electronic medical record by nursing staff. *That test was performed to check the thickness level of the blood and notifies the physician if the blood becomes dangerously thick or thin or has reached therapeutic levels.</p> <p>Interview on 6/7/16 at 3:55 p.m. with licensed practical nurse (LPN) E regarding laboratory orders for resident 3 revealed: *She was unable to find an order for a PT/INR in his electronic medical record but thought one had been performed possibly last Friday.</p> <p>Interview and record review on 6/8/16 at 11:15 a.m. with registered nurse (RN) F regarding resident 3's current medical status revealed: *She stated: -He had complained of a very sore right lower leg last week. -His pain was not relieved with Tylenol. -They had received an order from the resident's physician to send him to the hospital to have him evaluated. -Upon examination he was found to have a blood</p>	F 280	<p>The DON updated resident 3 care plan on 6/7/2016 with recent diagnosis and interventions for anti-coagulant therapy. On 6/28/2016 the DON confirmed that an order for PT/INR was in place on the MAR on 6/8/2016 for resident 3. On 6/28/2016 the DON reviewed resident 3 medical record and noted that resident 3 order for PT/INR was discontinued upon return from a hospital stay on 6/13/2016. By 7/29/2016 the DON or her designee will review every medical record to ensure that all orders, including lab orders, are properly located under the orders tab per the Point Click Care (PCC) manual step by step guide to entering physician's orders. The DON will provide an in-service for all nursing staff on 7/7/2016 on properly entering all orders under the orders tab per the PCC manual step by step guide to entering physician's orders. Beginning 7/29/2016 the DON or her designee will randomly audit 4 medical records per week x 4 weeks and then monthly thereafter. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p>	7/29/2016

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F 280	<p>Continued From page 8</p> <p>clot in his right lower leg. -He returned to the facility with physician orders to begin warfarin and lovenox medication. *She was unaware if he had any history of blood clotting problems or was on any other similar medications. *She was unaware of: -The need for bleeding precautions for resident's at risk for falls. -The need for increased bleeding precautions given the extra medications he had been receiving for his recent blood clot. -The need for staff to take extra precautions when caring for him by not massaging his calf muscle on his right leg. -The clot could have been accidentally dislodged from its location in his lower leg by massage, and caused it to travel to other parts of his body, and become potentially fatal. *She agreed if there was no physician's order transcribed by nursing staff for a PT/INR, it would be likely a laboratory blood draw could be missed, and the resident might experience complications from therapy.</p> <p>Interview on 6/9/16 at 10:20 a.m. with the director of nursing regarding resident 3's care plan revealed it was her expectation nursing staff were to have updated and revised the residents care plan to reflect the need for bleeding precautions.</p> <p>Review of the provider's undated Registered Nurse job description revealed duties included initiating and modifying the resident's plan of care as circumstances dictated.</p> <p>Review of the provider's 9/14/12 Plan of Care policy revealed it was: *Based upon the identification of the resident's</p>	F 280	<p>The DON reviewed and revised "Updating Care Plan" policy on 6/28/2016 to read "care plan will be updated by a nurse on an ongoing basis, and reviewed and updated quarterly, as appropriate, and upon significant change." The DON will complete a personal in-service with LPN E and RN F over "Updating Care Plan" policy by 7/1/2016 to ensure understanding of the need for staff to frequently update residents care plan to ensure staff is assisting resident in attaining his/her highest level of well-being. The DON will provide an in-service on this policy on 7/7/2016 for all Bethany nurses. The DON and Nurse Managers will review all resident care plans by 7/29/2016 to identify any other residents who may need care plans updated with current diagnosis and interventions. Beginning 7/29/2016 the DON or her designee will conduct an audit of all care plans to ensure proper diagnosis and interventions are in place. Random audits of four care plans will be conducted by the DON or her designee weekly for four weeks and then monthly thereafter. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p>	

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F 280	Continued From page 9 condition and needs. *Used to assist the resident in attaining his or her highest practicable level of well being.	F 280			
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: 36413 Based on observation, interview, and record review, the provider failed to clarify entered physician's orders in the computerized plan of care who had medications ordered for 5 of 11 sampled residents (1, 2, 3, 6, and 9). 1. Review of resident 2 and 9's medical record revealed: *They had been prescribed mirtazapine (an antidepressant sometimes used for sleep) fifteen milligrams at bedtime on 4/28/16 and 9/18/15 respectively by their primary care providers. *There was not a diagnosis noted on the medication administration records (MAR) for the above medication. *There was no documentation nursing staff had clarified the reason for use with their primary care providers. 2. Review of resident 6's medical record revealed: *She had been prescribed cyanobalamin (vitamin B12) one hundred milligrams once daily on 6/6/16 by her primary care physician. *There was no diagnosis noted on the MAR for	F 281	The DON reviewed residents 1, 2, 3, 6, and 9 MAR on 6/29/2016. For resident 9 the DON confirmed that the diagnosis was clarified with the physician and was placed in resident 9 MAR on 6/26/2016. For resident 2 the DON received clarification of the diagnosis on 6/29/2016 and placed the diagnosis on resident 2 MAR. For resident 6 the DON confirmed that the diagnosis was clarified with the physician and that the diagnosis had been placed in resident 6 MAR on 6/26/2016. For resident 1 the DON confirmed that the diagnosis was clarified with the physician and had been placed in resident 1 MAR on 6/26/2016.	7/29/2016	

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
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F 281	<p>Continued From page 10 the above medication *There was no documentation nursing staff had clarified the reason for use with her primary care provider.</p> <p>Surveyor: 35625 3. Review of the resident 1's medical record revealed: *She had been prescribed clopidogrel bisulfate (medication to prevent blood clots) seventy-five milligrams daily on 2/27/16 by her primary care provider. *There was no diagnosis on the medication order or MAR for the above medication. *There was no documentation nursing staff had clarified the reason for use with her primary care provider.</p> <p>Interview on 6/9/16 at 9:00 a.m. with the director of nursing (DON) regarding resident 1 revealed: *There was no diagnosis present for the above medication. *She did not offer information regarding her expectation of the nursing staff for clarifying physician's orders.</p> <p>Surveyor: 33488</p> <p>4. Review of the medical record for resident 3 revealed: *His admission date was 1/7/16. *He had a history of stroke and was taking aspirin and Plavix to help prevent blood clots from forming. *He was recently discharged from the hospital with physician's orders to begin warfarin and lovenox. *Those medications are commonly called "blood thinners".</p>	F 281	<p>For resident 3 DON confirmed that the diagnosis was clarified with the physician and had been placed in resident 3 MAR on 6/26/2016. Diagnosis for Warfarin was not placed on resident 3 MAR due to the physician order on 6/13/2016 for medication to be discontinued. On 6/28/2016 the DON confirmed that an order for PT/INR was on resident 3 MAR as of 6/8/2016; however, the PT/INR order was discontinued on 6/13/2016 so there was no further need to place this order in resident 3 medical record.</p>		

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F 281	<p>Continued From page 11</p> <p>*Warfarin required a special monitoring laboratory test called a prothrombin time/international normalized ratio (PT/INR).</p> <p>*That test checks the thickness level of the blood and alerts the physician if the blood becomes dangerously thick, thin, or has reached therapeutic levels.</p> <p>*No physician's orders for a PT/INR had been transcribed into his physician's orders section of his electronic medical record (EMR).</p> <p>Review of the MAR and physician's order summary report for resident 3 revealed:</p> <p>*Of the two new medication he was receiving (warfarin and lovenox) there was no associated diagnosis listed with it in the physician's order.</p> <p>*Lyrica (nerve pain medication) had the wrong diagnosis entered into the physician's order.</p> <p>-The diagnosis associated with the Lyrica was heart block.</p> <p>-That is not a medication used for heart block.</p> <p>5. Interview on 6/7/16 at 3:55 p.m. with licensed practical nurse (LPN) E regarding laboratory orders for resident 3 revealed:</p> <p>*She could locate no order for a PT/INR in his EMR.</p> <p>*She thought a test had been performed possibly last Friday on 6/3/16 and an order to repeat the test was made by the physician, but could not find one in the EMR.</p> <p>*That was not a common practice by staff to transcribe laboratory orders into the EMR.</p> <p>6. Interview and record review on 6/8/16 at 11:15 a.m. with registered nurse (RN) F regarding resident 3's current medical status revealed:</p> <p>*An order was received from the resident's physician to send him to the hospital to have him</p>	F 281	<p>On 6/29/2016 the DON reviewed "Administering Medications" Policy and found it to be correct. A personal in-service will be provided by DON to LPN E and RN F by 7/1/2016 to review the survey findings and on "Administering Medications" to ensure their understanding of this policy to include giving the right medication for the right reason prior to administering medication. The DON will provide an in-service to all Nursing staff on 7/7/2016 on the "Administering Medications" policy. The DON or her designee will review all MARs to ensure proper diagnosis has been obtained or clarified with physicians and attached to proper medication before 7/29/2016.</p> <p>Beginning 7/29/2016 DON or her designee will randomly audit four MARs weekly x four weeks and then monthly thereafter to ensure proper diagnosis are attached to medications and that all orders including lab draws are placed under the orders tab in PCC. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p> <p>On 6/29/2016 the DON and interdisciplinary team reviewed "Transcribing Physician Orders" policy and found it to be correct. The DON will give LPN E and RN F a personal in-service to review the survey findings and on the PCC manual step by step guide to entering physician orders and on the "Transcribing Physician Orders" policy by 7/1/2016. The DON will provide in-service training on the PCC step by step guide to entering physician orders and the "Transcribing Physician Orders" policy on 7/7/2016 for all nursing staff.</p>		

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F 281	<p>Continued From page 12 evaluated.</p> <p>*Upon examination he was found to have a blood clot in his right lower leg.</p> <p>*He returned to the facility with physician orders to begin warfarin and lovenox medication.</p> <p>*She was unaware if he had any history of blood clotting problems or was on any other similar medications.</p> <p>*She was unaware of the need to transcribe the physician's order whether written or telephone, into the EMR.</p> <p>*Staff would not commonly transcribe laboratory orders into the EMR.</p> <p>*She agreed unless staff had been working she supposed they would not know about the PT/INR order that had been received.</p> <p>*She agreed their should have been a physician's order transcribed into the EMR so nursing staff:</p> <p>-Were aware the laboratory blood draw needed to be obtained.</p> <p>-Laboratory values would be monitored closely by nursing staff and the physician notified accordingly.</p> <p>*All nursing staff have privileges to enter physician's orders into the EMR</p> <p>*She agreed all orders should have been transcribed into the EMR.</p> <p>Resident 3's warfarin and lovenox had no diagnoses associated with those medications, documented on the medication administration record (MAR) or on the physician's order section of the EMR.</p> <p>*The medications should have had accompanying diagnoses.</p> <p>*They were being administered for treatment for his blood clot.</p> <p>*Another medication listed on his MAR was Lyrica.</p>	F 281		

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F 281	<p>Continued From page 13</p> <p>*She was unsure why the diagnosis for Lyrica was heart block, as that is not a medication given for that reason. -She believed that had been an error. *Nursing staff should have always checked to see they are giving the right medication for the right reason prior to administration. *Nursing staff used the Lippincotts Nursing Drug Guide 2016 available at each nurses station if they had questions regarding a medication and indications for use.</p> <p>Interview on 6/9/16 at 10:20 a.m. with the DON regarding resident 3's care plan revealed it was her expectation nursing staff were to: *Have entered all physician's orders into the EMR. *Diagnoses associated with medications were to be accurate and completed.</p> <p>Review of the provider's Lippincotts Nursing Drug Guide 2016, pages 1189 and 1190, revealed one of its indication for use was diabetic peripheral neuropathy (nerve pain). There was no documentation to support an indication for use on residents with a history of heart block.</p> <p>5. Review of the manual for the EMR system located at each nurses station revealed: *A step-by-step guide to entering physician's orders. *The instructions only referred to medications and not for any other type of physician's order.</p> <p>Review of the provider's undated Registered Nurse job and Licensed Practical Nurse job descriptions revealed: *They were to be aware of new [physicians] orders and assist in transcribing and carrying out</p>	F 281	<p>The DON reviewed LPN and RN job descriptions on 6/29/2016 and found them to be correct. The DON will provide a personal in-service to LPN E and RN F by 7/1/2016 to review the survey findings and on their job description to ensure understanding of their complete job description to include monitoring laboratory values and notifying physician accordingly, entering orders into MAR, administering medications with the awareness that an error could be detrimental to the life or well-being of the resident and maintaining accurate and concise records by documenting all pertinent data. The DON will provide in-service training to all nursing staff on 7/7/2016 on job descriptions to ensure their understanding of expectations in fulfilling their job duties and responsibilities.</p>		

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F 281	Continued From page 14 those orders. *Administer medications with the awareness that error could be detrimental to the life or well-being of the resident. *Maintain accurate and concise records by documenting all pertinent data.	F 281		
F 323 SS=D	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: 16385 Based on observation, interview, and review of the manufacturer's operating instructions, the provider failed to ensure three of three observed EZ Way Stands (mechanical lifts used for transferring residents) had safety tabs per manufacturer's instructions. Findings include: 1. Observations during the following times revealed: *On 6/7/16 at 7:45 a.m. two EZ Way Stand mechanical lifts on Promise Lane had no safety tabs attached to the harness attachment area. *On 6/7/16 at 8:00 a.m. one EZ Way Stand mechanical lift on Dakota Lane had no safety tabs attached to the harness attachment area. *On 6/9/16 at 7:45 a.m. the same one EZ Way Stand mechanical lift on Dakota Lane had no	F 323		

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F 323	Continued From page 15 safety tabs attached to the harness attachment area. *On 6/9/16 at 7:50 a.m. the same two EZ Way Stand mechanical lifts on Promise Lane had no safety tabs attached to the harness attachment area. *Those safety tabs were to ensure the sling loops were secured within the harness hookup, so residents would not have fallen from the mechanical lift. Observation and interview on 6/7/16 at 4:30 p.m. with the maintenance director revealed he had a bag of replacement safety tabs. He stated maintenance staff had replaced the safety tabs on all stand lifts, but the certified nursing assistants (CNA) would remove them. Review of the provider's EZ Stand Operating Instructions maintenance checklist revealed: *"The manufacturer suggests that the following components and operating points be scheduled for inspection at intervals not greater than one month. Any detected deficiency must be rectified before the device is put back into service." *"5. Safety tabs need to be checked to make sure they are installed correctly, not missing or torn."	F 323	On 6/7/2016 the Maintenance Director immediately replaced safety tabs on all EZ Way Stands. On 6/30/2016 the Administrator, DON, and interdisciplinary team created "Safe Lifting and Movement of Residents" policy which includes direction that staff are not to remove functioning safety tabs from EZ Way Mechanical Lifts. The DON will provide in-service training to all staff on 7/7/2016 to review the survey findings and on importance of safety tabs on EZ Way stands. Beginning 7/29/2016 DON or her designee will complete random audits two times per week for four weeks and then monthly thereafter on all EZ Way stands to ensure that the safety devices are in place. The DON or her designee will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.	7/29/2016	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387			

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F 387	<p>Continued From page 16</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on record review, interview, and policy review, the provider failed to ensure a physician's visit had been completed on a resident every sixty days from July 2015 through June 9, 2016, for 1 of 11 sampled residents (5). Findings include:</p> <p>1. Review of resident 5's medical record revealed: *She had been admitted on 7/9/11. *Physician assessments and progress notes from July 2015 through June 9, 2016, had been completed on 7/29/15, 10/24/15, 12/28/15, and 3/12/16. *There had been eighty-seven days between the 7/25/15 and 10/24/15 assessments. -That assessment had been twenty-seven days late. *There had been seventy-five days between the 12/28/15 and 3/12/16 assessments. -That assessment had been fifteen days late. *There had been no assessments between 3/12/16 through exit from the facility by the survey team on 6/9/16. -It had been eighty-nine days since the last assessment. -It had been documented the physician had been contacted by phone or facsimile on 5/5/16, 5/10/16, and 5/16/16 to notify him the resident needed to be assessed.</p> <p>Interview with the director of nursing on 6/9/16 at 9:00 a.m. revealed it was the expectation the resident be assessed every sixty days by the medical provider.</p>	F 387	<p>On 6/13/2016 resident 5 physician assessed the resident for her 60 day Nursing Home Visit. The DON reviewed and revised on 6/29/2016 the "Physician Visits" policy in collaboration with the Medical Director to include: "In the Event of physician delinquency with this policy, the person in charge of obtaining physician visit will contact the Administrator, DON, and/or Medical Director in order to obtain physician's prompt compliance with this policy." The DON will provide in-service training to all nursing staff on 7/7/2016 on the revised "Physician Visit" policy. Beginning 7/29/2016, the DON will conduct monthly audits of the nursing secretary's list of physician renewals at the beginning of every month to make certain that an appointment is set up appropriately to ensure physicians visit every 60 days. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p>	7/29/2016

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F 387	Continued From page 17	F 387		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</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</p>	F 431		

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F 431	<p>Continued From page 18</p> <p>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: 33488 Based on observation, interview, medication cart review, medication room review, and policy review, the provider failed to: *Reconcile two of two unopened controlled narcotic medications (tramadol and lorazepam) not in use and located in one of two nursing units (Dakota Drive). *Destroy controlled narcotic Fentanyl (pain medication) patches by a nurse and another witness. *Count as needed (prn) controlled narcotic medication on two of two nursing units (Primrose Lane and Dakota Drive). *Secure one of two medication carts (Primrose Lane) from unauthorized access. *Dispose of eye drops appropriately within manufacturer's guidelines once opened and prior to expiration for three randomly sampled residents (17, 18, and 19). Findings include:</p> <p>1. Observation and interview on 6/7/16 at 3:45 p.m. with licensed practical nurse (LPN) E in the medication room on Dakota Drive revealed: *A bottle of unopened narcotic pain medication, lorazepam, was stored in the medication refrigerator. *It had been there since 5/6/16 as a prn</p>	F 431	<p>The pharmacist and the DON reviewed the "Controlled Substances" policy on 6/28/2016 and found it to be correct. On 6/7/2016 the DON properly disposed of Resident 16 unopened bottle of narcotic pain medication, lorazepam. On 6/7/2016 the DON counted and reconciled resident 10, 13, 20, and 21 PRN narcotics. The DON documented results on the Narcotic Count Sheet for each resident and placed these sheets into the shift to shift count book for continued accountability. The DON will provide a personal in-service to RN F and LPN G on the "Controlled Substance" policy by 7/1/2016. The DON will provide in-service training on 7/7/2016 to all nursing staff to review the survey findings and regarding the "Controlled Substances" policy to ensure that staff is responsible for medication administration and associated accountability. Beginning 7/29/2016, the DON or her designee will conduct a weekly audit for four weeks and then monthly thereafter of the narcotic sheets to ensure proper count, reconciliation, and documentation of narcotics for each resident per the "Controlled Substances" policy. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p>	7/29/2016	

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F 431	<p>Continued From page 19</p> <p>medication but had never been used by resident 16.</p> <p>*There was no count sheet to verify staff were tracking of contents of the bottle to avoid theft or diversion.</p> <p>*Staff would not count narcotic controlled medication until it had been opened and used by a resident.</p> <p>*Nursing staff disposed of controlled narcotic Fentanyl patches after removing them from the resident by:</p> <ul style="list-style-type: none"> -Placing them in a chemical solution. -Shaking the container; the solution dissolved the patch. -Signing the medication administration record (MAR). -The process of destruction was no longer witnessed as it used to be when disposed of in a different manner. <p>Interview on 6/8/16 at 2:15 p.m. with LPN E and the director of nursing (DON) on Dakota Drive regarding resident 16's above medication revealed:</p> <ul style="list-style-type: none"> *Resident 16's medication was still in the medication room's refrigerator. *Resident 16 had died on 6/7/16. *The DON was unaware the resident had a bottle of unopened narcotic controlled lorazepam. *LPN E was reported to have given the DON all of resident 16's medication on 6/7/16. <p>Interview on 6/8/16 at 11:38 a.m. with registered nurse (RN) F regarding Fentanyl patch destruction revealed there was no witnessing of the destruction of Fentanyl patches.</p> <p>2. Medication cart review and interview on 6/8/16 at 2:15 p.m. with LPN E and the director of</p>	F 431	<p>In collaboration with the pharmacist, the DON reviewed and revised the "Fentanyl Destruction" policy on 6/28/2016 to state "Two nurses or Nurse and Medication Aid will sign off regarding the disposal of used patch on narcotic count sheet that it was properly destroyed".</p> <p>Beginning 7/29/2016, the DON or her designee will audit narcotic count sheets to ensure that two nurses or a nurse and a medication aid jointly destroyed and documented the destruction of Fentanyl patches. These audits will be completed weekly for four weeks and then monthly thereafter. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p> <p>The DON will provide in-service training on 7/7/2016 to all nursing staff to review the survey findings and on the updated "Fentanyl Destruction" policy and to ensure that staff is responsible for medication administration and associated accountability.</p>	

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F 431	<p>Continued From page 20</p> <p>nursing (DON) on Dakota Drive revealed:</p> <p>*Cough syrup with codeine (narcotic controlled medication) was in the bottom drawer of the cart. *It was unopened and had no content count sheet and was not counted by nursing staff.</p> <p>*Two controlled narcotic medication blister packs had no count sheets attached for residents 10 and 13.</p> <p>-There was no way to readily identify how many tablets of the controlled narcotic medication should be remaining in those blister packs.</p> <p>Continued review of the medication cart on Dakota Drive revealed:</p> <p>*Four bottles of eye drop medication that were not labeled with an expiration date after they were opened for residents 17, 18 and 19.</p> <p>*Labels on each bottle had an area to write in an opened on date and an expired by date.</p> <p>*The opened date was the only date that staff had written in the area.</p> <p>*Resident 17's eye drop medications (latanoprost and timolol) had been labeled with opened dates on 4/19/16 and 4/23/16 but had not been labeled with expiration dates.</p> <p>*Resident 18's eye drop medication bottle latanoprost had been labeled with an opened date of 4/25/16 but no expired by date.</p> <p>*Resident 19's latanoprost's bottle had been labeled with an opened date of 5/13/16 but no expired by date.</p> <p>Review of the manufacturer's guidelines for timolol and latanoprost accessed on 6/9/16 http://www.news-medical.net/drugs revealed:</p> <p>***Eye drops contain a preservative which helps prevent germs growing in the solution for the first four weeks after opening the bottle.</p> <p>***After this time there is a greater risk that the</p>	F 431	<p>Unopened Cough syrup with codeine was removed and destroyed from the medication cart by the DON on 6/8/2016 due to non-usage. An order to discontinue this medication was obtained.</p> <p>In collaboration with the pharmacist, the DON wrote "Storage and Expiration of Medications" policy in order to clarify eye drop storage parameters. On 6/8/2016 the DON confirmed that the charge nurse properly labeled or removed if the open dates and expiration dates were outside of the recommended parameters of the opened eye drops for resident's 17, 18, and 19.</p> <p>The DON will provide in-service training to all nursing staff on 7/7/2016 to review the survey findings and regarding the "Storage and expiration of Medications" policy to ensure understanding of medication storage parameters with emphasis on the need to document open date and expiration date. Beginning 7/29/2016, the DON or her designee will conduct weekly audits on all medication carts for four weeks and then monthly thereafter to ensure open dates and expiration dates are on all eye drops in accordance with storage parameters. The DON will report these audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</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: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/09/2016
NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 21 drops may become contaminated and cause an eye infection."</p> <p>3. Observation and interview with LPN G during review of one of two medication carts on promise lane revealed: *Four additional blister packs of controlled narcotic medication that had count sheets missing that belonged to residents 20 and 21. *PRN controlled narcotics normally had a count sheet rubber-banded with them, however they were not counted daily. *One blister pack of controlled narcotic medication belonging to resident 21 revealed the last date signed on the sheet had been 3/28/16. *That was the last date she had received medication from that blister pack. *There was no count sheet verifying staff had counted the controlled narcotic medication for reconciliation against theft or diversion.</p> <p>4. Interview on 6/9/16 at 10:20 a.m. with the DON regarding the above observations revealed: *She was unaware Fentanyl patch destruction must be done by a nurse in the presence of a witness when using a chemical destroyer. *They had changed the method of destruction of patches earlier in 2016. *They had previously required a two person witness and sign-off of the destruction of the Fentanyl patches. *It was her expectation all controlled narcotic medication was to have been counted upon receipt and daily thereafter by nursing staff. *She was unaware of the uncounted narcotic lorazepam for deceased resident 16. *She agreed she had no way of knowing the lorazepam was still in the refrigerator had it not been brought to her attention at the time of the</p>	F 431	<p>The DON reviewed the "Security of Medication Cart" policy on 6/29/2016 and found it to be correct. The DON will provide a personal in-service to LPN B by 7/1/2016 on the "Security of Medication Cart" policy. The DON will provide in-service training to all nursing staff on 7/7/2016 to review the survey findings and on "Security of Medication Cart" policy. Beginning 7/29/2016, the DON or her designee will conduct three random medication cart audits per week for four weeks and then monthly thereafter to ensure that the medication carts are locked. The DON will report audit findings to the quarterly QAPI Committee for as long as the Committee deems necessary.</p>	

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
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F 431	<p>Continued From page 22 interview the previous day. *She was unaware the above eye drop medications would expire within four weeks according to manufacturer's guidelines once they had been opened.</p> <p>Review of the provider's 2/8/16 Fentanyl-Duragesic Patch Disposal policy revealed no mention of destruction by a nurse in the presence of a witness.</p> <p>Review of the provider's 2001 Controlled Substances policy revealed: *They must be counted upon delivery by two nursing staff. *Both individuals must sign the controlled substance record at that time. *A record must be made for each resident who was to have received a controlled substance and only one substance was allowed per page. *Nursing staff were to count all controlled substances at the end of each shift.</p> <p>Surveyor: 35625 5. Observation on 6/8/16 from 7:48 a.m. through 7:58 a.m. in the hallway outside the Promise Lane dining room revealed: *One of two medication carts was unlocked. *The nurse was passing medications in the dining room and only intermittently present at the unlocked medication cart. *Nursing staff were not able to directly observe the medication carts continuously during the above time. *Multiple residents and staff walked by the carts during the above time.</p> <p>Interview and observation on 6/8/16 at 7:58 a.m.</p>	F 431			

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
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F 431	Continued From page 23 with licensed practical nurse B regarding the above medication carts revealed: *The carts were to be locked when not in use. *She locked the cart at that time. Review of the providers June 2016 Security of Medication Cart policy revealed: *"The nurse must secure the medication cart and treatment cart during the medication pass to prevent unauthorized entry. *The carts must be locked before the nurse enters the resident's room. *Medication carts and treatment carts must be securely locked at all times when out of the nurse's view."	F 431			
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review and interview, the provider failed to submit an accurate Centers for	F 514			

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
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F 514	<p>Continued From page 24</p> <p>Medicaid and Medicare (CMS) Form 802 (which provided a list of resident names and quality indicator [problems or needs of the residents]) to the survey team upon arrival to the facility to conduct a recertification survey. Findings include:</p> <p>1. Observation and interview on 6/7/16 from 7:30 a.m. through 9:15 a.m. of the survey process revealed:</p> <ul style="list-style-type: none"> *The survey team entered the facility at 7:30 a.m. *The director of nursing (DON) and administrator arrived and were given a list of required documentation needed to precede with the survey process. *The Minimum Data Set (MDS) coordinator and the DON began working on the CMS form 802. *The CMS form 802 was presented to the team leader at 9:00 a.m. by the DON. <p>Review of the CMS form 802 revealed:</p> <ul style="list-style-type: none"> *There are thirty categories that may be filled in if applicable to each resident according their individual needs. *Of the total residents documented on the form: <ul style="list-style-type: none"> -Five of forty-seven residents had no check marks or indicators selected. -Twenty-three of forty-seven residents had two or less check marks or indicators selected on the form. -Seven of forty-seven residents had three check marks or indicators each selected. -Twelve of forty-seven residents had four checkmarks or more. *There was not enough information indicated on the form to accurately reflect each residents' individual needs. <p>Interview on 6/7/16 at 9:15 a.m. with the DON immediately following review of the CMS form</p>	F 514	<p>On 6/27/2016 the DON and the MDS Coordinator contacted Point Click Care (PCC) to report concerns with PCC accurately pulling data from the last locked MDS to the 802. At this time PCC is unable to identify anything within the PCC program that is contributing to the 802 inaccuracies. On 6/27/2016, PCC provided written instruction to the DON and MDS Coordinator regarding the completion of the 802 including the need to complete weekly updates as well as the need to update after each resident admission and discharge. On 6/27/2016 the DON and MDS Coordinator reset in PCC the resident information necessary for the completion of the 802. As a result, an accurate 802 was produced. By 7/1/2016 the DON will provide a personal in-service to the MDS Coordinator regarding the PCC written instructions for the completion of an 802. Emphasis will be placed on the need for updates per the PCC instructions in order to ensure the timely and accurate completion of an 802 when requested by a surveyor. Beginning 7/29/2016 the DON will conduct a weekly audit of the 802 in PCC to ensure that updates are being completed by the MDS Coordinator as instructed and to ensure the accuracy of the 802.</p> <p><i>*The DON will report findings to the quarterly QAPI committee for as long as the committee deems necessary. NPN/SPD/HJL</i></p>	7/29/2016

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
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F 514	<p>Continued From page 25</p> <p>802 revealed:</p> <ul style="list-style-type: none"> *They had issues every year with getting an accurate CMS form 802 to print. *She was told by the previous DON there was nothing they could do about it. *She agreed it was likely not an accurate reflection of the residents' MDS information. *She stated she was going to continue to work on the electronic medical record system with the MDS coordinator. *They preferred to fill out the form electronically instead of it being handwritten. *She would inform the administrator of continuation of the survey process without an accurate CMS form 802. <p>Prior to the end of the survey, the administrator stated:</p> <ul style="list-style-type: none"> *They had no policy for how to accurately complete an CMS form 802 . *They had no instructions in their manual regarding the CMS form 802 in their electronic medical records program, Point Click Care. 	F 514			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/08/2016
NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 6/8/16. Bethany Home Sioux Falls (Building 01) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

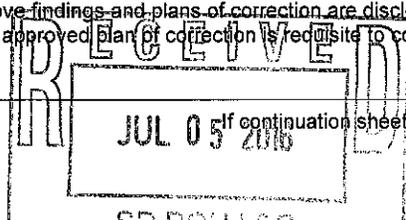
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Monica Newstead

Administrator

7/12/2016

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.



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

ORIGINAL

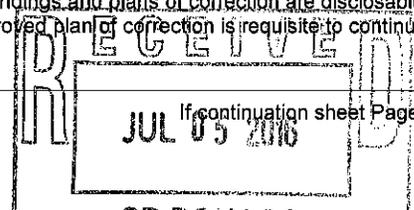
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____		(X3) DATE SURVEY COMPLETED 06/08/2016
NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
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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 6/8/16. Bethany Home Sioux Falls (Building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000			

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

Sharon Stewart Administrator 7/1/2016

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.



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SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10677	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/09/2016
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NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 S HOLLY AVENUE SIOUX FALLS, SD 57105
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S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/7/16 through 6/9/16. Bethany Home Sioux Falls was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/7/16 through 6/9/16. Bethany Home Sioux Falls was found in compliance.	S 000		

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

Alvina H. Hunsold

TITLE

Administrator

(X6) DATE

7/1/2016

STATE FORM

6899

028811

If continuation sheet 1 of 1

