### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>DATE COMPLETION OATC</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>Surveyor: 22452 A reclassification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 3/27/18 through 3/29/18. Bethany Home - Brandon was found not in compliance with the following requirements: F680 and F680.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F 680</td>
<td>Bowel/Bladder Incorrection, Catheter, UTI CFR(e): 483.25(e)(1)-(3)</td>
<td>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless he or her clinical condition is or becomes such that continence is not possible to maintain.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that: (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LAboratory Director or Provider/Supplier Representative's Signature**

*Hunters Winklepuck*

**Title**: Administrator

**Date**: 04/16/2018

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 disclosed 59 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above deficiencies/deficiency are disclosed 14 days following the date these documents are made available to the facility. If deficiencies are cited, an expedited plan of correction is necessary for continued program participation.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREP Prefix/TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>OBS COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 690 | Continued From page 1 | §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 18580
Based on record review, interview, and procedure review, the provider failed to ensure an appropriate bowel management program had been implemented for two of two sampled residents (8 and 13) with bowel management concerns. Findings include:

1. Review of resident 13's medical record revealed:
   *She was admitted on 12/16/14.
   *Her diagnoses included aphasia, dementia, anxiety, depression, and psychotic disorder.

   Review of resident 13's 12/26/17 quarterly Minimum Data Set (MDS) assessment revealed:
   *She was on a scheduled medication regimen.
   *She was always incontinent of bowel.
   *No constipation problem.

   Review of resident 13's 1/15/18 care plan revealed:
   *A focus area related to pain due to chronic physical disability.
   *Interventions included to:
     -Monitor and document side effects of pain medication.
     -Observe for constipation. | F 690 | | | |
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F 690 | Continued From page 2 | | Review of resident 13's February 2018 medication administration record (MAR) revealed: *Pain medications included:  
-Fentanyl Patch 72 hour, 25 mcg per hour,  
-Acetaminophen 650 mg, four times a day.  
-Acetaminophen 650 mg, every four hours as needed (prn).  
-Ibuprofen tablet 400 mg, every six hours prn.  
* Constipation medications included:  
-Mirasol powder 17 gram, one time a day.  
-Mirasol powder 17 gram, daily prn.  
-Milk of Magnesia 30 mL, daily prn.  
-Bisacodyl suppository, every 96 hours prn for no bowel movement (BM) in three days.  
-Review of resident 13's 2/5/18 through 3/2/18 bowel continence look back report revealed she had no recorded BMS from:  
*2/6/18 through 2/10/18, five days.  
*2/21/18 through 3/1/18, nine days.  
-Further review of resident 13's February 2018 MAR revealed no prn medications for constipation had been given during the above dates.  
-2. Review of resident 8's medical record revealed:  
*She was admitted on 1/13/17.  
*Her diagnoses included arthritis, osteoporosis, Alzheimer's disease, anxiety, and depression.  
*She was admitted to Hospice care on 9/15/17.  
-Review of resident 8's 12/20/17 quarterly MDS revealed:  
*She was on a scheduled pain medication regimen.  
*She was always continent of bowel.  
*No constipation problem. | F 690 |
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 690</td>
<td>Continued From page 3</td>
<td>F 690</td>
<td></td>
</tr>
</tbody>
</table>

Review of resident 8's 12/26/17 care plan revealed:
*A focus area related to not being able to voice if having pain.
*Interventions included to:
 - Administer pain medications per doctor's order.
 - Monitor for side effects of pain medications.

Review of resident 8's March 2018 MAR revealed:
*Pain medications included:
 - Acetaminophen 500 mg, four times a day.
 - Acetaminophen 500 mg, every four hours pm.
 - Morphine 0.5 ml, every hour pm.
*Constipation medications included:
 - Senexon-S tablet 8.6-50 mg, two times a day.
 - Dosage increased 3/15/18 to two tablets, two times a day.
 - Milk of Magnesia 30 cc, every 24 hours pm.
 - Bisacodyl suppository, every 24 hours pm.

Review of resident 8's 3/6/18 to 3/16/18 bowel continence look back report revealed she had no recorded BMs from:
*3/6/18 to 3/9/18, four days.
*3/11/18 to 3/15/18, five days.

Further review of resident 8's March 2018 MAR revealed:
*She had refused her scheduled Senexon-S on 3/6/18, 3/7/18, and one dose on 3/14/18.
*No pm medications for constipation had been given during the above dates.

3. Interview on 3/29/18 at 8:00 a.m. with certified nursing assistant/medication administration aide (CNA/MA) regarding residents' bowel
**Summary Statement of Deficiencies**

**F 690** Continued From page 4

1. BMs were recorded on the bowel continence look back report.
2. If no BM for three days then prune juice would have been given.
3. If no BM for four days then Miralax would have been given.
4. After four days nurses decided the next step.

Interview on 3/29/18 at 10:00 a.m. with registered nurse/neighborhood leader G regarding residents' bowel management revealed:

1. Ideally residents should not go longer than three days without a BM.
2. Residents received prune juice on day three and then Milk of Magnesia.
3. CNAs/As documented BMs on the bowel continence look back report and reported any concerns to the nurse.
4. Nurses checked the bowel continence look back report for any concerns.
5. Residents' BMs should have been monitored and documented appropriately.

Review of the provider's unattended Bowel Movements procedure revealed:

1. The purpose was to ensure every resident had a bowel movement every three days.
2. The overnight nurse shift printed the bowel continence look back report and notified the day shift.
3. If residents required a prn medication to assist with their bowels the night shift would administer suppositories prior to the end of their shift.
4. The day shift nurses were responsible for oral prn medications as needed.
5. All nurses were to be aware of a resident's bowel status and to intervene with scheduled/prn medication as needed.
F 690 Continued From page 5 resident.

F 880 Infection Prevention & Control

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions

F 690

F 880 F880: A directed in-service and competency review will be held by the DON or her designee on 04/23/2018 for CNA’s A, C, and all staff regarding proper hand hygiene while caring for residents.

CNA B was a student studying under Bethany leadership. The DON will contact CNA B’s program instructor by 05/18/2018 so she can receive the proper in-service from her instructor.

The DON in coordination with the interdisciplinary team reviewed the Policy and Procedure related to proper hand hygiene on 04/10/2018.

The DON or designee will audit proper hand hygiene beginning on 04/16/2018 once a week for four weeks and monthly for two more months.

The DON or designee will present the findings of the audit to the QAPI committee, at the quarterly meeting, who will review and make recommendations, 04/13/2018

Resident 4 and all other residents with a glucometer had their glucometer properly cleaned on 04/13/2018 by the Neighborhood Leaders.

Each resident who has a glucometer will have their names printed on a label which will be placed on their individual glucometer on 04/15/2018 by the Neighborhood Leaders to better identify who each glucometer belongs to.

A directed in-service and competency review will be held by the DON or her designee on 04/23/2018 for MA D, RN E and all nursing staff regarding the proper procedure for cleaning glucometers
Continued From page 6

(F 880) to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which 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; and
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:
Surveyor: 38999
Based on observation, interview, policy review, and manufacturer's instructions review, the provider failed to:
*Ensure appropriate hand hygiene and glove use during residents (10 and 11) personal care for two of five observations of personal care by three certified nurse assistants (A, B, and C).
<table>
<thead>
<tr>
<th>ID PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td></td>
</tr>
</tbody>
</table>

Continued From page 7

*Follow manufacturer's instructions related to cleaning and disinfection of the glucose meter for three of three observed glucometer blood sugar checks for one of one resident (4) by two of two medication aide (MA) D and registered nurse (RN) E staff.

Findings Include:

1a. Observations on 3/27/18 at 2:42 p.m. during resident 10's personal care by certified nursing assistants (CNAs) A and B revealed:
*No hand washing was observed by both CNAs A and B before the direct contact with the resident.
*No hand washing was observed by both CNAs A and B before putting on a pair of gloves.
*CNA A changed her pair of gloves four times while providing personal care for the resident.
-She left a pair of soiled gloves on and placed a clean protective undergarment on the resident.
-She removed her soiled gloves and went out of the resident's room to get the Hoyer lift.
-She put a pair of clean gloves on, moved the bage of soiled garbage and linens from the middle of the floor to the side of the wall, and transferred the resident with a Hoyer lift from the bed to her wheel chair.
-She removed her soiled gloves and placed clean slipper socks on the resident's feet.
*There was no hand washing observed four times between glove changes.
*That was four missed opportunities to perform hand hygiene to prevent the spread of infection.
*CNA B changed her pair of gloves two times while assisting CNA A with providing personal care for the resident.
-She left a pair of soiled gloves on, went into the resident's bathroom to get a clean protective undergarment, and assisted with moving the resident from side-to-side to apply the...
F 880 Continued From page 8

undergarment.
-She left a pair of soiled gloves on after direct
resident care, picked up the bag of soiled
garbage and linens, and left the resident’s room.
*There was no hand washing observed two times
between glove changes.
*That was two missed opportunities to perform
hand hygiene to prevent the spread of infection.

Interview on 3/27/18 at 3:18 p.m. with CNAs A
and B regarding hand hygiene revealed:
*Both agreed they should have performed hand
hygiene before and after direct resident contact.
*Both agreed they should have performed hand
hygiene between glove changes.

b. Observation on 3/28/18 at 4:24 p.m. during
resident 11’s personal care by CNA C revealed:
*She assisted the resident with ambulating with
her walker from her room to the bathroom.
-No hand washing was observed by CNA C
before the direct contact with the resident.
*She put on a pair of gloves to assist the resident
with personal hygiene after toileting.
*She assisted the resident with ambulation while
wearing the same pair of gloves.
-No hand washing was observed before putting a
pair of gloves on.
-No removal of gloves after assisting the resident
with the use of the toilet.
*She removed the pair of soiled gloves, placed
soap in her hands, rubbed hands together, and
then wiped her hands on the resident’s towel.

Interview on 3/28/18 at 4:34 p.m. with CNA C
regarding hand hygiene revealed:
*She agreed she should have performed hand
hygiene:
*Before and after direct resident contact.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 880</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

- **F 880** Continued From page 9
  - Between glove changes.
  - She should wash her hands with soap and water to prevent the spread of infection.

- Observation on 3/27/18 at 11:52 a.m. of MA D during resident 4's glucose check using the blood glucose meter revealed:
  - She placed the meter in the cart.
  - There was no observation of cleaning and disinfecting the meter.

- Observation on 3/27/18 at 5:05 p.m. of MA D during resident 4's glucose check using the blood glucose meter revealed:
  - She placed the meter on top of the medication cart.
  - There was no observation of the meter being placed on a clean barrier.
  - She used a Sani-Cloth AF3 to wipe the surface of the meter off and placed the meter back in the cart.

- Observation on 3/28/18 at 3:54 p.m. of registered nurse (RN) E during resident 4's glucose check using the blood glucose meter revealed:
  - She placed the meter on top of the medication cart.
  - There was no observation of cleaning and disinfecting the meter.

- Interview on 3/28/18 at 4:45 p.m. with RN E regarding the cleaning and disinfection of the blood glucose meter revealed:
  - She said, "Each resident has their own blood glucose meter and I usually clean and disinfect the meter daily."
  - Resident 4 was the only resident on Willow Wood Way that had blood glucose checks.
  - There was some black markings on the meter.
Continued from page 10

that were not readable.

"She stated, "Those markings were [resident 4's]
name."

3. Interview on 3/26/18 at 11:22 a.m. with the
director of nursing (DON) regarding the above
observations revealed she would have expected
all staff to:
*Do appropriate hand hygiene to prevent the
spread of infections.
*Follow the policy to clean and disinfect the blood
sugar meter to prevent the potential
transmission of infection.

Review of the August 2014 revised Hand
Washing/Hand Hygiene policy and procedure
revealed:
**This facility considers hand hygiene the primary
means to prevent the spread of infections.
*All personnel shall follow the hand washing/hand
hygiene procedures to help prevent the spread of
infections to other personnel, residents, and
visitors.
*Use an alcohol-based hand rub containing at
least 62% alcohol; or, alternatively, soap
(antimicrobial or non-antimicrobial) and water for
the following situations:
- Before and after direct contact with residents.
- Before 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 objects (e.g., medical
equipment) in the immediate vicinity of the
resident.
- After removing gloves.*

Review of the 9/8/16 Clean and Disinfect the
Blood Glucose Meter policy and procedure
revealed:
**Purpose:** To prevent the potential transmission of infectious organisms when using the glucose meter.

*Each resident must have their own glucose meter.*

-The device is to be cleaned and disinfected with a Sani-Cloth bleach wipe (1:10 dilution) between each glucose check.

-Wrap the wipe around the glucose test strip insertion site for at least four minutes."

Review of the manufacturer's instructions for the AF3 Sani-Cloth wipes to disinfect revealed:

"Unfold a clean wipe and thoroughly wet surface.

"Allow treated surface to remain wet for three (3) minutes. Let air dry."
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CMS IDENTIFICATION NUMBER:
435130

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
03/29/2018

NAME OF PROVIDER OR SUPPLIER

BETHANY HOME - BRANDON

STREET ADDRESS, CITY, STATE, ZIP CODE
3912 E ASPEN BLVD
BRANDON, SD 57005

(X4) ID TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEG IDENTIFYING INFORMATION)

E 000 Initial Comments

Surveyor: 22452
An initial survey for compliance with all Federal emergency preparedness requirements was conducted from 3/27/18 through 3/29/18. Bethany Home - Brandon was found in compliance with 42 CFR Part 483.73 requirements.

E 000

ID TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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

Hunter Winkleplack

TITLE
Administrator

DATE
04/16/2018

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 following documents must be made available to the surveyor 40 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the following documents must be made available to the surveyor 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approval of these corrections is necessary to continued program participation.

FORM CMS-2567(02-69) Previous Versions Obsolete
Event ID: DBEX11

Continuation sheet Page 1 of 1

SD DOH-OLC
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA ID</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>435130</td>
<td>A. BUILDING 01</td>
<td>03/29/2018</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF PROVIDER OR SUPPLIER</th>
<th>STREET ADDRESS, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td>BETHANY HOME - BRANDON</td>
<td>3012 E ASPEN BLVD BRANDON, SD 57005</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>TAG</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td></td>
<td>K 000</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**INITIAL COMMENTS**

Surveyor: 25107

A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/29/18. Bethany Home - Brandon was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

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

Hunter Winkleplack

**TITLE**

Administrator

**DATE**

04/16/2018

---

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.) Expect exceptions for certain deficiencies which are discloseable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes the 90 days begin the day after the date of survey. In other cases the disclosure date is 14 days following the date these documents are made available to the facility. If deficiencies are not corrected and/or continued, this facility may not be eligible to continue program participation.
## Summary Statement of Deficiencies

**S 000 Compliance/Noncompliance Statement**

Surveyor: 22452
A recertification survey for compliance with the Administrative Rules of South Dakota, Article 44.73, Nursing Facilities, was conducted from 3/27/18 through 3/29/18. Bethany Home - Brandon was found in compliance.

---

**S 000 Compliance/Noncompliance Statement**

Surveyor: 22452
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 3/27/18 through 3/29/18. Bethany Home - Brandon was found in compliance.