Surveyor: 29354
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/23/19 through 9/26/19. Bethesda Home of Aberdeen was found not in compliance with the following requirements: F658 and F880.

F 658 Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)

§483.21(b)(3) Comprehensive Care Plans
The services provided or arranged by the facility, as outlined by the comprehensive care plan, must:
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Surveyor: 40771
Based on observation, interview, record review, and policy review, the provider failed to follow physician's orders for one of one sampled resident (31) who had a chronic recurring facility acquired pressure ulcer. Findings include:

1. Review of resident 31’s medical record revealed:
*An admission date 3/9/18.
*Diagnoses: type two diabetes with diabetic neuropathy, spinal stenosis.

Review of a 11/1/18 physician’s order for resident 31 revealed:
*“Patient [resident] to ambulate 4 x [times] per day.
*Four times a day for pressure ulcer lower back.
*Ensure pt [patient] ambulates 4 times per day.”
<table>
<thead>
<tr>
<th>F 658</th>
<th>Continued From page 1</th>
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</thead>
<tbody>
<tr>
<td>Observation and interview on 9/23/19 from 4:37 p.m. through 5:02 p.m. with resident 31 revealed:</td>
<td></td>
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<tr>
<td>*At 4:37 p.m.: *</td>
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<td>-He was in a wheelchair (w/c) in his bathroom attempting to pull his pants up.</td>
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<td>-He moved himself from the bathroom to the living area.</td>
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<td>-He stated he had sores on his bottom for over a year:</td>
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<td>--It would heal.</td>
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<td>--It would reopen.</td>
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<td>--It was currently opened.</td>
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<td>-His physician told him he needed to get out of his w/c and walk if he wanted the sores to heal.</td>
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<td>-One of the staff had told him he needed to have a staff person assist him to use the walker.</td>
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<td>-He felt there were not enough staff to help him walk when he used the walker.</td>
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<td>*At 5:02 p.m.: *</td>
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<td>-An unidentified staff person came into his room and offered to take him to the dining area.</td>
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<tr>
<td>-He was not asked if he wanted to walk to the dining area.</td>
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<tr>
<td>-She pushed him in his w/c to that area.</td>
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</tbody>
</table>

Observations on 9/24/19 at the following times of resident 31 revealed:
*At 7:45 a.m.: *
-He was in the dining area in his w/c.
-The walker was not present at the table.
*At 11:55 a.m.: *
-He was being pushed by a staff member in his w/c to the dining area.
-The walker was not present.
*At 4:45 p.m.: *
-He was being pushed by a staff member in his w/c to the dining area.
-The walker was not present.

The physician order and comprehensive care plan for resident 31 was reviewed by DON and Inservice Coordinator. DON and Inservice Coordinator reviewed and re-educated nursing and restorative therapy staff who provide care for this resident on his specific physician ordered walking program related to his chronic wound including following care plans and proper documentation was completed by 10/18/19. Upon review by DON and Restorative Coordinator no other residents were identified with a pressure injury and a physician ordered walking program. When a physician ordered walking program is received the nurse will now also notify the Restorative Coordinator, who will oversee the setup of the walking program. Inservice Coordinator will provide education regarding physician ordered walking programs, following care plans, and documentations to the remaining nursing staff, activities, and dietary personal by 10/21/19. Visual and documentation audits, along with resident interviews, will be conducted by Resident Care Coordinator, or designee. Audits will be conducted three times per week for 1 month, then once per week until QAPI Committee decides to discontinue. The Resident Care Coordinator will report all findings to the DON. The DON will report monthly to the QAPI Committee and
Continued From page 2
Observations on 9/25/19 at the following times of resident 31 revealed:
*At 11:58 a.m.:
- He was being pushed by a staff member into the dining area in his w/c.
- The walker was not present.
*At 5:40 p.m.:
- He was in the dining area in his w/c.
- The walker was not present at the table.

Observation on 9/28/19 at 11:42 a.m. of resident 31 revealed a staff member was pushing him in his w/c to the dining area. The walker was not present.

Interview on 9/25/18 at 2:16 p.m. with registered nurse (RN) H regarding resident 31 revealed:
*She did not attend specialized training for pressure ulcers.
*Recently three other staff members had been sent to the training.
*RN H did all the resident measurements and documentation on pressure injuries and venous injuries.
*His pressure ulcer would heal up and close, but then reopen and drain.
*There was another staff member who assisted with wound care that had attended the above specialized training for pressure ulcers.

Interview by telephone on 9/25/19 at 10:20 a.m. with licensed practical nurse (LPN) F, physician G's nurse regarding resident 31, revealed:
*Physician G was not in the office at that time.
*She was familiar with him and the physician's plan of care for him.
*The physician had diagnosed the wound as: "Chronic/recurrent/sacral/inner/midback/wound/ulcer."

quarterly to the Quality Assurance Committee with the Medical Director.

10/18/19
F 658  Continued From page 3  
*He was seen in May 2019 in their clinic for the wound.  
*He did not see the wound care team at [hospital name], because they told the facility had their own wound nurse.  
*The physician had written the order for him to walk to dining, because he had reported he was not getting walked by the staff.  
*The physician and she had come to an interdisciplinary team meeting and discussed the staff needed to offer to walk him, because he might not want to bother them.  

Continued interview on 9/26/19 at 11:01 a.m. with resident 31 revealed:  
*He believed they did not have enough staff to walk him.  
*If he asked a staff member to walk him to meals then they would.  
*He did not like to ask the staff members, because he knew they were very busy.  
*He had not walked today to breakfast, because they had used the w/c to take him to get a bath.  
*After his bath they used the w/c to take him to the dining room.  
*He used to walk a lot before he was admitted.  
*It was getting harder to walk, because he had not been walking as much.  
*He felt his health was declining, because he could not walk without staff assistance.  

Interview on 9/26/19 at 11:21 a.m. with the director of nursing regarding resident 31 revealed:  
*He received restorative therapy one time a day for five days a week.  
*His pressure ulcer would heal and close, and then reopen and drain.  
*The certified nursing assistants (CNA) should
<table>
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<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tr>
<td>F 658</td>
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<td>have offered to walk him to all meals.</td>
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<td>-This was in addition to restorative therapy.</td>
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<td>*He often refused for various reasons when the CNAs asked him.</td>
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<td>*She had seen him walking but was not sure how often.</td>
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<td>-It was probably at lunch time, because that was when she was in the building.</td>
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<td>*The wound nurse had not had any certification or training specifically on wound treatment.</td>
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<td>*They would use [hospital names] wound clinic for residents if the physician had made a referral.</td>
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</table>

Review of the September 2019 treatment administration record for resident 31 revealed on:
*9/23/19: he had refused to walk to the dining area for his 5:00 p.m. meal.
*9/26/19: Documentation revealed he had walked to breakfast and lunch.

Review of resident 31's 7/31/19 quarterly Minimum Data Set (MDS) assessment revealed:
*He:
-Required one person with limited assistance to walk.
-Was not steady when standing, walking, or turning around.
-In the seven days during the assessment period he had not refused any care.
*The Brief Interview for Mental Status assessment score was fifteen indicating there was no cognitive impairment.

Review of resident 31's weekly wound observation tool from May 2019 through September 26, 2019 revealed:
*The pressure ulcer on his lower back was coded as facility acquired.
*On 5/21/19; he occasionally refused to walk to
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<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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</table>
| F 658         | Continued From page 5  
dine because he does not want to wait for assistance."  
*There was no further documentation for refusal to walk-to dine.  
*He was on a turning and repositioning routine.  
*The pressure ulcer had not healed.  
Review of the provider’s 8/24/17 Pressure Injury Prevention and Management policy revealed:  
*When they received physician's orders the facility would follow them specifically.  
*The wound nurse would notify the physician if the pressure ulcer was not healing and would get recommendations and new orders. | F 658         | Magic Erasers were removed from all bathing rooms on 9/27/19 by DON.  
Whirlpool policy was reviewed by the Infection Control Coordinator with scheduled bath aides on 9/26/19.  
By removing Magic Erasers this has eliminated the storage of cleaning tools with personal care items.  
Purchasing Coordinator has been informed to no longer purchase Magic Erasers for bathing rooms.  
Infection Control Coordinator will provide education on proper disinfecting practice per manufacturers instruction on the whirlpool tub cleaning/facility policy and proper storage of cleaning tools and personal care items to all scheduled bath aides by 10/18/19.  
New bath aides will go through a bath aide competency with the | |
| F 880         | Infection Prevention & Control  
CFR(s): 483.80(a)(1)(2)(4)(e)(f)  
§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 (IPC) 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 | F 880         | |

**NAME OF PROVIDER OR SUPPLIER**

**BETHESDA HOME OF ABERDEEN**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1224 S HIGH ST  
ABERDEEN, SD 57401

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CILIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>435073</td>
<td>A. BUILDING</td>
<td>09/26/2019</td>
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F 880
Continued From page 6
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
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.

Infection Control Coordinator prior
to completion of their training and
annually thereafter. Directed
Inservice Training will be held on
10/21/19 to review infection control
policies and procedures. Each
department will review their roles
and responsibilities for infection
prevention and control including
a review of the specific cited areas
of deficiencies. Infection Control
Coordinator, or designee will audit
proper tub disinfection. Audits will
be done daily for 1 week, then three
times a week for 1 week, then
weekly for 1 month, then once a
month until the QAPI Committee
decides to discontinue. The
Infection Control Coordinator will
report all findings to the DON. The
Infection Control Coordinator will
report audits monthly to the QAPI
Committee and quarterly to the
Quality Assurance Committee with
the Medical Director.

Education was provided by Infection
Control Coordinator to Housekeeper
B and D of proper disinfection
around personal care items;
Housekeeper D was also educated
on proper sanitizing protocol (time
chemical needs to set on surface)
per policy on 9/27/19. On 10/3/19
proper resident room cleaning and
disinfecting was discussed with all
housekeeping staff by the Infection
Control Coordinator and Administrator. New Housekeepers will go through a disinfecting competency with the Infection Control Coordinator prior to training completion. Annual competency education will be completed with all scheduled housekeepers on disinfecting and proper cleaning around personal care items. Directed Staff Inservice Training will be held on 10/21/19 to review infection control policies and procedure. Each department will review their role and responsibilities for infection prevention and control including a review of the specific cited area of deficiencies. Infection Control Coordinator will audit proper use of chemicals around personal hygiene items and proper sanitizing protocol weekly for 4 weeks, then monthly until the QAPI Committee decides to discontinue. The Infection Control Coordinator will report all findings to the DON. The Infection Control Coordinator will report all audit findings to monthly QAPI Committee and quarterly to the Quality Assurance Committee with the Medical Director.
F 880  Continued From page 8

bath.

*Soiled, used Magic erasers were discovered in a storage cabinet and had been placed inside a container along with a resident's hygiene and care supplies.

Interview on 9/25/19 at 4:18 p.m. with the infection control nurse regarding cleaning of the whirlpool tubs revealed she:
*Had been unaware that CNA A used Magic erasers to scrub the inside of the tub.
*Would not want the used Magic erasers to be stored along with resident activity of daily living (ADL) supplies.
*Would expect the bath aides to follow their policy and procedure for proper whirlpool tub cleaning and to use the scrub brush provided.

Observation on 9/26/19 from 9:35 a.m. to 10:37 a.m. revealed soiled, used Magic erasers stored in tub rooms A, E, and G had dirty, used Magic erasers stored along with residents' ADL supplies.

Review of the manufacturer's instructions for use of the Magic erasers revealed they were a single use item.

Review of the provider's revised 6/18/15 Whirlpool Cleaning procedure revealed: "Finish rinsing the interior surfaces of the tub with the shower sprayer. Start the air blower by pushing the Aqua-Aire button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system. Stop the Aqua-Aire blower by again pushing the Aqua-Aire button."
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<tbody>
<tr>
<td>F 880</td>
<td>Continued From page 9 Interview on 9/26/19 at 8:27 a.m. with the director of nursing (DON) regarding whirlpool tub cleaning revealed she: *Had been unaware the bath aides were using Magic erasers for the tub cleaning. *Stated the Magic erasers would be a single-use item if they had been used for cleaning. *Would not want the dirty Magic erasers to be stored in the with residents' ADL supplies. *Would expect the bath aides to follow their policy and procedure for cleaning the whirlpool tubs. Interview on 9/26/19 at 10:47 a.m. with CNA E regarding the procedure for cleaning the whirlpool tubs revealed the CNAs that were the bath aides had used Magic erasers on tubs. It was their practice to reuse them. 2. Observation on 9/24/19 at 3:22 p.m. of housekeeper B and observation on 9/25/19 at 10:14 a.m. of housekeeper D cleaning two random residents' bathrooms revealed: *They had both used a spray bottle with disinfectant to spray the sink in the bathrooms. *The back of the sinks each had an empty denture cup with the lid opened located beside the faucets along with other personal ADL grooming supplies including toothbrushes, toothpaste tube, and emesis basin. *They had not removed those items prior to spraying the sink which could cause the spray particles to fall onto the items. *Housekeeper D had not allowed ten minutes for sanitizing prior to wiping down the sink with a clean cloth. Further interview on 9/25/19 at 4:18 p.m. with the infection control nurse regarding the housekeeper cleaning of the residents' bathrooms revealed:</td>
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| | | "Spray bathroom cleaner in sink and on faucet. Spread and wipe around sink and faucet with clean, dry rag. Wipe countertop, picking up and moving personal items on counter as you go along. Using dry rag, wipe inside of sinks and faucets. Chrome faucets should have a polished look. Be sure to put personal items back in their
<table>
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<th>ID</th>
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<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>
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<td>F 880</td>
<td>Continued From page 11 original spots.</td>
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**NAME OF PROVIDER OR SUPPLIER**

BETHESDA HOME OF ABERDEEN

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1224 S HIGH ST

ABERDEEN, SD 57401

**DATE SURVEY COMPLETED**

09/26/2019
**NAME OF PROVIDER OR SUPPLIER**

**BETHESDA HOME OF ABERDEEN**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1224 S HIGH ST

ABERDEEN, SD 57401

### SUMMARY STATEMENT OF DEFICIENCIES

**ID** E 000

**PREFIX TAG** Initial Comments

Surveyor: 29354

A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/23/19 through 9/26/19. Bethesda Home of Aberdeen was found in compliance.

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

Scott Eisenbeisz

**TITLE** EPH-Administrator

**DATE** 10-18-19

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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. Adequate proof of acceptance by the residential care facility or nursing home, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction has been or is being implemented. 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.
Surveyor: 40506
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/24/19. Bethesda Home of Aberdeen was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222, K322, K362 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

Egress Doors

Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:

CLINICAL NEEDS OR SECURITY THREAT LOCKING
Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.

18.2.2.2.5.1, 18.2.2.2.8, 19.2.2.2.5.1, 19.2.2.2.6

SPECIAL NEEDS LOCKING ARRANGEMENTS
Where special locking arrangements for the safety needs of the patient are used, all of the...
K 222 Continued From page 1

Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.

18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4

DELAYED-EGRESS LOCKING ARRANGEMENTS

Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.

18.2.2.2.4, 19.2.2.2.4

ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS

Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.

18.2.2.2.4, 19.2.2.2.4

ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS

Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.

18.2.2.2.4, 19.2.2.2.4

This REQUIREMENT is not met as evidenced by:
<table>
<thead>
<tr>
<th>K 222</th>
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<tr>
<td></td>
<td>Surveyor: 40506</td>
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<tr>
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<td>Based on observation, testing, and interview, the provider failed to provide egress doors as required at five (corridors B, C, E, G, and H) of eight locations (at front entrance and corridors B, C, D, E, F, G, and H) in the nursing home. Findings include:</td>
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<tr>
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<td>1. Observations at 9:40 a.m., 10:00 a.m., 10:30 a.m., 11:15 a.m., and 12:30 a.m. on 9/24/19 revealed the exit doors equipped with delayed egress hardware and within the nursing home (at corridors B, C, E, G, and H) prevented egress unless unlatched with a badge. The exit doors were labeled as delayed egress locked doors. Testing of the doors by applying force in the direction of the path of egress revealed the audible signal would not sound and the doors would not release with pressure. The required irreversible process of unlocking the door did not initiate.</td>
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<td>Interview at the time of the observation with the plant operations manager and administrator confirmed those conditions. Maintenance staff worked diligently to correct the issue, and after resetting the system multiple times on 9/24/19, the doors were functional in the afternoon.</td>
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<td>Failure to provide egress doors as required increases the risk of death or injury due to fire.</td>
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<td>The deficiency affected five of eight exit doors.</td>
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<td>Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)</td>
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<tr>
<td>K 321</td>
<td>Hazardous Areas - Enclosure</td>
</tr>
<tr>
<td>SS=D</td>
<td>CFR(s): NFPA 101</td>
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As stated in the surveyor's observations the exit doors were corrected on 9/24/19 and continued to operated as equipped through survey as observed by team lead. Corrective action was accomplished by resetting all of the doors alarmed by the wandergaurd system. Education was provided to maintenance staff on how to reset door system on 10/16/19. To achieve sustained compliance, each door will be inspected and tested by maintenance or designed daily times four weeks then weekly times three months. Then door checks will be added to monthly preventative maintenance.

Maintenance supervisor will report results to Administrator. The Administrator will report audit findings to QAPI Committee monthly.
K 321 Continued From page 3

Hazardous Areas - Enclosure
Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9.
When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door.
Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9

Area Separation N/A Automatic Sprinkler
a. Boiler and Fuel-Fired Heater Rooms
b. Laundries (larger than 100 square feet)
c. Repair, Maintenance, and Paint Shops
d. Soiled Linen Rooms (exceeding 84 gallons)
e. Trash Collection Rooms (exceeding 84 gallons)
f. Combustible Storage Rooms/Spaces (over 50 square feet)
g. Laboratories (if classified as Severe Hazard - see K322)
This REQUIREMENT is not met as evidenced by:
Surveyor: 40506
Based on observation and interview, the provider failed to maintain two separate hazardous areas (garage and building supplies room in the maintenance area) due to combustible storage in an area not protected by functional closers as required. Findings include:
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>435073</td>
<td>A. BUILDING 01 - MAIN BUILDING 01</td>
<td>09/24/2019</td>
</tr>
<tr>
<td></td>
<td>B. WNG</td>
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**NAME OF PROVIDER OR SUPPLIER**

BETHESDA HOME OF ABERDEEN

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1224 S HIGH ST
ABERDEEN, SD 57401

**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 321         | Continued From page 4 | K 321 | The closers on the two doors were replaced on 10/16/19 by Maintenance supervisor. The Maintenance supervisor evaluated the other closers to make sure they were in working order and noted no other issues with the other current closers. Door Closer in the garage area will be added to the Preventive Maintenance checklist for monthly inspection. Maintenance Supervisor or designee will audit weekly for four weeks then monthly for five months for proper door closing. Then it will be added to monthly preventative maintenance program. Results of audits will be reported to the Administrator who will take the results to monthly QAPI meeting. | 10/18/19 |

| K 362         | Corridors - Construction of Walls CFR(s): NFPA 101 | K 362 | Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are | |
| K 362 | Continued From page 5 in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating __________ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain a corridor separation from a maintenance closet (room labeled as sprinkler control). Findings include:

1. Observation at 1:30 p.m. on 9/24/19 revealed an egg crate louver in the corridor wall. The louver supplied air to a maintenance closet that contained both fire sprinkler controls and a small air handling unit. The plant operations manager explained the room size was not adequate to provide supply air for the air handling unit.

   Interview with the plant operations manager and the administrator at the time of the observations confirmed the finding.

   The deficiency had the possibility of affecting all occupants of the smoke compartment.

Reference 2012 Life Safety Code 19.3.6.4.1

| K 712 | Fire Drills CFR(s): NFPA 101

Fire drills include the transmission of a fire alarm

Identified egg crate louver in the corridor wall was removed and appropriate sheetrock was replaced and wall was repaired to create 1/2 hour fire resistance rating. This was completed on 10/16/19. No other areas were observed to have been created with other louver systems within the building. Maintenance staff was provided inservice training on the importance of maintaining smoke and fire barrier on 10/16/19. Smoke/fire barrier penetration will be added to work project checklist for projects completed for both in-house and those completed by outside vendors. Maintenance supervisor will report any findings to Administrator. Administrator will take findings to monthly QAPI meeting.

10-18-19
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| K712 |        |     | Continued From page 6 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review and interview, the provider failed to ensure staff were familiar with the provider’s fire drill procedures (inadequate number of required fire drills in quarter two, January, February, March; and an inadequate number of fire drills in quarter three, April, May, June). Findings include:

1. Record review at 4:15 p.m. on 9/24/19 revealed there was no documentation of third shift fire drills for quarter two (January, February, March) or quarter three (April, May, June) in 2019.

Interview with the plant operations manager and administrator at the time of the record review confirmed those findings. He was unaware the minimum number of fire drills per the required frequency had not been met for each shift for 2019.

The deficiency had the potential to affect 100% of the occupants of the building. | K712 |        |     | Education was provided by EPH-Administrator to Maintenance Supervisor and staff and also Director of Employee Environment that fire drills need to be conducted once a quarter per shift at varies times and locations throughout the building. Education occurred on 10/16/19. A scheduled will be developed to ensure drills will be held at a minimum of quarterly per shift at varying times by Maintenance Supervisor or designee to ensure compliance. Review of the fire drill logs will be conducted by the Administrator or designee monthly and will report the findings to the monthly QAPI meeting for one year.
K.000

INITIAL COMMENTS

Surveyor: 40506
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/24/19. Bethesda Home of Aberdeen was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K.712

Fire Drills
CFR(s): NFPA 101

Fire Drills
Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 5:00 AM, a coded announcement may be used instead of audible alarms.

19.7.1.4 through 19.7.1.7
This REQUIREMENT is not met as evidenced by:

Surveyor: 40506

Based on record review and interview, the provider failed to ensure staff were familiar with the provider’s fire drill procedures (inadequate number of required fire drills in quarter two, January, February, March; and an inadequate

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Scott Eisenbeisz

EPH-Administrator 10-18-19
Continued From page 1
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