F 000 INITIAL COMMENTS

Surveyor: 36413

A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/10/19 through 6/12/19. Bethany Home - Brandon was found not in compliance with the following requirements: F557, F661, F677, F679, F686, F689, F880.

F 657 Care Plan Timing and Revision
CFR(s): 483.21(b)(2)(i)-(ii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(I) Developed within 7 days after completion of the comprehensive assessment.
(II) Prepared by an interdisciplinary team, that includes but is not limited to-
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s).
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(II) Reviewed and revised by the interdisciplinary team after each assessment, including both the interdisciplinary assessment and the resident's representative.

F 657 F557: Resident 41 was reassessed for elopement risk on 06/27/2019 by the nurse management team. His wander guard was moved from his wheelchair to his wrist because the resident is able to walk and does not always have his wheelchair. This did prevent him from leaving the facility unattended. His care plan was updated accordingly.

The interdisciplinary team reviewed the resident's care plan and updated the care plan with the following interventions on how to intervene appropriately if he is actively seeking to exit the facility. These interventions include offering to sit down and visit with coffee and cookies. The resident responds well when offered food. Most often when the resident is wandering he is looking for his wife, so his wife suggested we tell him she is on her way to the facility.

The OCN or designee will complete assessments for all residents by 07/20/2019 and will update the care plans with the appropriate interventions to prevent elopement if the resident is deemed at risk for elopement. This is inclusive of the placement of the location of the resident's wander guard alert not being on the resident's wheelchair if a wander guard is deemed necessary and the resident is capable of walking. These assessments will be completed every quarter by the neighborhood leaders or as needed if a resident becomes at risk for elopement.

The interdisciplinary team created an Elopement Risk Assessment policy on 06/26/2019 which includes the questions to ask when determining if a resident is at risk for elopement. The policy was approved by the facility QAPI team on 06/26/2019.

A Directed Interivew will be held by the OCN or designee on 07/20/2019 and 07/27/2019 for all staff regarding their roles and responsibilities for ensuring resident quality of care and quality of life related to timely care plan revisions for residents identified at risk for elopement and the recently adopted elopement risk assessment policy.

Beginning 07/20/2019, the OCN or designee will audit weekly x4 then monthly thereafter that all residents identified at risk for elopement have a care plan that is updated with appropriate interventions to elopement, inclusive of where the resident's wander guard alert is placed if a wander guard is being utilized.

The OCN or designee will present the findings of the audit to the QAPI committee at the monthly meeting for review and recommendation for actions to be taken.

The interdisciplinary team consulted with resident 41's wife on 07/02/2019 to identify individualized interventions to gain her cooperation with washing his hand to handle assaults. The care plan was updated with these interventions.

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

Hunter Winklepleck

TITLE

Administrator

(D) DATE

07/03/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency that may be used as evidence to correct the deficiency. Providing it is determined that other safeguards provide sufficient protection to the patients, deficiencies noted in this document, the findings stated above are discloseable 90 days following the date of survey whether or not a plan of correction is filed. 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 application of correction is requested to continued program participation.
**NAME OF PROVIDER OR SUPPLIER**

**BETHANY HOME - BRANDON**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 657</td>
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</tbody>
</table>

**ADDRESS**

**3012 E ASPEN BLVD**

**BRANDON, SD 57005**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/ SUPPLIER/ CLIA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>435130</td>
<td>A. BUILDING</td>
<td>06/12/2019</td>
</tr>
<tr>
<td></td>
<td>B. WING</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F 657</strong> Continued From page 1 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:</td>
<td></td>
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<tr>
<td>Surveyor: 35121</td>
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<tr>
<td>Based on record review, interview, and policy review, the provider failed to update care plans to reflect the current needs for one of fifteen sampled residents (41). Findings include:</td>
<td></td>
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<tr>
<td>1. Interview on 6/11/19 at 1:00 p.m. with certified nursing assistant (I) regarding resident 41 revealed:</td>
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<tr>
<td>*He routinely wandered within his neighborhood. *His wandering increased at night.</td>
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<tr>
<td>Review of his medical record revealed he had:</td>
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<tr>
<td>Review of his 5/21/19 care plan revealed:</td>
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<tr>
<td>*He had attempted to leave the facility unattended. *He required physical assist with the act of bathing. *Staff were to:</td>
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<tr>
<td>-&quot;Anticipate and meet his needs.&quot; -&quot;Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: visiting, coffee and cookies, and seeing what is all going on.&quot;</td>
<td></td>
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<tr>
<td>-&quot;Identify pattern of wandering: is wandering purposeful, aimless, or escapist? Is resident</td>
<td></td>
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</tbody>
</table>

**ID PREFIX TAG**

<table>
<thead>
<tr>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>F 657</strong> The interdisciplinary Team reviewed the policy and procedure for Bathing Residents and Care Planning on 06/26/2019 and determined no changes in policy were needed. The policy was reviewed and remains approved by the QAPI committee on 06/26/2019.</td>
<td></td>
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</tr>
<tr>
<td>A Directed Interventions will be held by the DON or designee on 07/02/2019 and 07/03/2019 for all staff regarding their roles and responsibilities for ensuring resident quality of care and quality of life relating to care plan timing and revision. Specifically in the areas of identifying appropriate interventions to ensure residents are receiving proper hygiene inclusive of bathing, how to document and update the care plan with resident specific interventions in goal cooperation with bathing when a resident refuses bathing, and the Policies for Bathing residents and care planning.</td>
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<tr>
<td>Beginning no later than 07/03/2019, the DON or designee will randomly audit 5 residents weekly and then monthly thereafter to monitor that residents have bathing preferences care plans, the interventions are included on how to handle resident refusal of bathing, that bathing documentation is being completed for all residents appropriately, and that resident are receiving their baths per their care plan.</td>
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<tr>
<td>The DON or designee will present the findings of the audit to the QAPI committee monthly for review and recommendation for action to be taken.</td>
<td></td>
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<tr>
<td>ID</td>
<td>ID Prefix Tag</td>
<td>Summary Statement of Deficiencies (each deficiency must be preceded by full regulatory or LSC identifying information)</td>
<td>ID Prefix Tag</td>
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<tr>
<td>F 657</td>
<td>Continued From page 2 looking for something? Does it indicate the need for more exercise? Intervene as appropriate [appropriate].&quot;  &quot;I require physical assist in the act of bathing.&quot;  &quot;No specific suggestions of how to intervene appropriately or to prevent him from leaving the facility untended.  &quot;No interventions for refusals of bathing.  Interview on 6/12/19 at 11:37 a.m. with the director of nursing regarding resident 41's care plan revealed she:  &quot;Agreed his care plan did not have specific interventions regarding his bathing refusals or prevention of elopement.  &quot;Would have expected his care plan to include more individualized interventions relating to his dementia to ensure he had been bathed regularly and would not leave unattended.  Review of the provider's November 2018 Plan of Care policy revealed:  &quot;An initial, individualized plan of care is developed upon admission.&quot;  &quot;An interdisciplinary plan of care...is based upon the identification of the resident’s condition and needs.&quot;  &quot;The plan of care identifies problems, approaches, goals, and the services necessary to assist the resident in attaining the highest practicable level of functioning.&quot;  &quot;Care Plans will be updated by staff on an ongoing basis.&quot;  Surveyor: 36413</td>
<td></td>
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</tr>
<tr>
<td>F 661</td>
<td>Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv)</td>
<td>F 661 F251: Resident 57's Recertification of Stay was completed on 07/01/2019 and entered into the Resident's Medical Record. An individual interview will be held prior to 07/09/2019 for Neighborhood Leader C by the DOH to ensure she is aware of proper recertification of</td>
<td></td>
</tr>
<tr>
<td>(X4) ID</td>
<td>PREFIX</td>
<td>TAG</td>
<td>(X5) COMPLETION DATE</td>
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<tr>
<td>F 661</td>
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</tbody>
</table>

**Summary Statement of Deficiencies**

(Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
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</table>

**Provider's Plan of Correction**

(Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)

<table>
<thead>
<tr>
<th>(X5) COMPLETION DATE</th>
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<tbody>
<tr>
<td>06/12/2019</td>
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</tbody>
</table>

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**F 661 Continued from page 3**

§483.21(c)(2) Discharge Summary

When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:

(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.

(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).

(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.

This REQUIREMENT is not met as evidenced by:

Surveyor: 18560

Based on record review and interview, the provider failed to ensure one of one discharged resident (57) had a recapitulation (recap) of stay summary completed at the time of discharge.

Findings include:

1. Review of resident 57's closed medical record revealed she had been discharged on 5/14/19.
### Statement of Deficiencies and Plan of Correction

| (X1) Provider/Supplier/CLA Identification Number: | 435130 |
| (X2) Multiple Construction: | A. Building: | B. Wing: |
| (X3) Date Survey Completed: | 06/12/2019 |

#### Name of Provider or Supplier
BETHANY HOME - BRANDON

#### Summary Statement of Deficiencies
Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID/Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 661</td>
<td>Continued From page 4</td>
<td></td>
</tr>
<tr>
<td>F 661</td>
<td>There was no recap of her stay in her medical record.</td>
<td></td>
</tr>
<tr>
<td>F 661</td>
<td>Interview on 6/12/19 at 4:24 p.m. with the director of nursing confirmed:</td>
<td></td>
</tr>
<tr>
<td>F 661</td>
<td>1. There was no recap completed for resident 57's stay.</td>
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<tr>
<td>F 661</td>
<td>2. She would have expected a recap to have been completed.</td>
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<tr>
<td>F 661</td>
<td>3. There was no policy for recap of stay in the progress and there should have been</td>
<td></td>
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</tbody>
</table>

#### Provider's Plan of Correction
Each corrective action should be cross-referenced to the appropriate deficiency.

<table>
<thead>
<tr>
<th>ID/Prefix</th>
<th>Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 677</td>
<td>ADL Care Provided for Dependent Residents</td>
<td></td>
</tr>
<tr>
<td>F 677</td>
<td>SS-D</td>
<td>CFR(s): 483.24(a)(2)</td>
</tr>
<tr>
<td>F 677</td>
<td>§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:</td>
<td></td>
</tr>
<tr>
<td>F 677</td>
<td>Surveyor: 35121</td>
<td></td>
</tr>
<tr>
<td>F 677</td>
<td>Based on family interview, observation, record review, and policy review, the provider failed to ensure one of one cognitively impaired sampled resident (41) reviewed for personal hygiene had received a shower or bath on a consistent basis. Findings include:</td>
<td></td>
</tr>
<tr>
<td>F 677</td>
<td>1. Observation and interview on 6/11/19 at 4:00 p.m. with resident 41's spouse revealed:</td>
<td></td>
</tr>
<tr>
<td>F 677</td>
<td>1. He was wearing a sweatshirt top, pants, socks, tennis shoes and glasses.</td>
<td></td>
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<tr>
<td>F 677</td>
<td>2. While his hair had a greasy appearance, his face and hands were not visibly soiled.</td>
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<tr>
<td>F 677</td>
<td>3. She voiced he had not consistently been showered weekly.</td>
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<tr>
<td>F 677</td>
<td>4. He would refuse many times when she was not there.</td>
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</tbody>
</table>

#### Completion Date
07/02/2019
F 677 Continued From page 5

*She felt he had not been showered weekly, in part because of his refusals, but wanted him to have been showered regularly when she was not able to be there.
- She would routinely be at there two to three days a week.
- She would ask if he had been showered. If he had not she requested staff to attempt at that time.
- He would shower when she told him he needed to.
*She was concerned that he would not get a shower if something happened to her.
- She had tried to keep track and thought he may not have received a shower since 5/28/19 or earlier.

Review of his medical record revealed he had a diagnosis of dementia without behavioral disturbance.

Review of his 5/9/19 annual comprehensive Minimum Data Set assessment (MDS) revealed he:
* Had short and long term memory loss.
* Had moderately impaired cognition (made poor decisions and required cues and supervision) regarding tasks of daily life.
* Required physical help of one staff person in part of the bathing activity.

Review of his Documentation Survey Reports from 3/1/19 through 6/11/19 regarding the bathing task revealed he had been bathed:
* One time in March on 3/25/19.
* Three times in April on 4/8/19, 4/18/19 and 4/22/19.
* One time in May on 5/9/19.
* One time in June on 6/6/19.
<table>
<thead>
<tr>
<th>F 677</th>
<th>Continued From page 6</th>
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</thead>
<tbody>
<tr>
<td>Interview on 6/12/19 at 11:31 a.m. with the director of nursing revealed she:</td>
<td></td>
</tr>
<tr>
<td><em>Confirmed he had not received a shower regularly.</em></td>
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</tr>
<tr>
<td><em>Would have expected staff to have attempted to shower him on other days and times if he had refused prior attempts.</em></td>
<td></td>
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</tbody>
</table>

Review of the provider's October 2010 Shower/Tub Bath procedure revealed:

"The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin."

"Should the resident become ill, faint, or uncooperative during the procedure, turn off the shower or open the drain plug. Cover the resident and summon the supervisor by using the emergency call system."

"Notify the supervisor if the resident refuses the shower/tub bath."

<table>
<thead>
<tr>
<th>F 679</th>
<th>Activities Meet Interest/Needs Each Resident</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=1D</td>
<td>§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Surveyor: 18580</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>F 679</th>
<th>Activity Director reviewed Resident 17's activity plan with Resident 17 on 06/28/2019 and updated her care plan with an increased number of activity interventions that are 1:1 and small group based on the resident's current preference.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Activity Director will review the activity plans of all residents, inclusive of those with severe limited mobility and little or no activity involvement, no later than 07/02/2019, to ensure all residents activity programs meet the interests of support the physical, mental, and psychological wellbeing of each resident.</td>
</tr>
<tr>
<td></td>
<td>The Interdisciplinary Team reviewed the Policies and Procedures for Activities on 06/28/2019 and no changes to the P&amp;P were made. The Policies and Procedures for Activities were approved to continue without changes by teh QAPI committee on 09/28/2019.</td>
</tr>
<tr>
<td></td>
<td>A Directed Exercise will be held on 07/02/2019 and 07/03/2019 by the Administrator for the Life Enrichment Coordinator and all staff regarding their roles and responsibilities for ensuring resident quality of care and quality of life relating to ensuring all resident’s activity programs meet the interests of and support the physical, mental, and psychological wellbeing of each resident.</td>
</tr>
<tr>
<td></td>
<td>Starting no later than 07/02/2019, the Life Enrichment Coordinator or designee will audit the Activity Care Plan and Documentation of Resident Activity Participation/Response for 5 Residents with little or no Activity Participation and/or Residents with Severe Limited Mobility weekly x12 weeks, and update the resident activity program if there is little or no participation or response.</td>
</tr>
<tr>
<td><strong>STATEMENT OF DEFICIENCIES</strong></td>
<td><strong>X1 PROVIDER/SETTING IDENTIFICATION NUMBER:</strong></td>
</tr>
<tr>
<td>And Plan of Correction</td>
<td>435130</td>
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</tbody>
</table>

| **X3 DATE SURVEY COMPLETED** |
| 06/12/2019 |

| **NAME OF PROVIDER OR SUPPLIER** |
| BETHANY HOME - BRANDON |

| **STREET ADDRESS, CITY, STATE, ZIP CODE** |
| 3012 E ASPEN BLVD |
| BRANDON, SD 57005 |

| **X4 ID TAG** | **SUMMARY STATEMENT OF DEFICIENCIES** |
| (Each deficiency must be preceded by full regulatory or LCS identifying information) |
| F 679 Continued From page 7 |

| **ID TAG** | **PROVIDER'S PLAN OF CORRECTION** |
| (Each corrective action should be cross-referenced to the appropriate deficiency) |
| F 679 Life Enrichment Coordinator or designee will present the findings of the audit to the QAP committee monthly for review and recommendations for actions to be taken |

- Based on observation, record review, interview, and policy review, the provider failed to provide ongoing activities for one of one sampled resident (17) with severely limited mobility. Findings include:

  1. Observation from 6/10/19 through 6/12/19 of resident 17 revealed she was constantly laying on her back in her bed watching TV.

  Review of resident 17's medical record revealed:
  * She was admitted on 5/24/14.
  * Her diagnoses included flaccid hemiplegia affecting her right dominant side, epilepsy, and morbid obesity.

  Review of resident 17's 3/22/19 annual Minimum Data Set assessment revealed:
  * Her cognitive skill for making daily decisions was modified independence.
  * It was very important for her to:
    - Have books, newspapers, and magazines to read.
    - Go outside to get fresh air when the weather was good.
  * It was somewhat important for her to:
    - Listen to music that she liked.
    - Be around animals such as pets.
    - Do her favorite things.

  Review of resident 17's last revised 6/18/18 activity care plan revealed:
  * She preferred solitary activity routines.
  * She continued to direct her activity routine and would be able to make her daily recreational choices clear as observed and charted by staff.
  * Interventions included:
    - Encourage ongoing family involvement, invite husband and children to attend special events,
**Bethany Home - Brandon**

<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>
</tr>
</thead>
</table>
| F 679         | Continued From page 8 activities, or meals.  
-She previously really enjoyed painting, drawing, quilting, and crocheting.  
--Discuss these activities and inform of opportunities to try them.  
-Chaplain would visit regularly.  
-She watched TV in her room.  
--Offer discussion regarding the TV programs or commercials as appropriate.  
-Her favorite activities included reading (mystery or adventure books), listing to music (oldies, country, hymns, Statler Brothers), watching game shows on TV (anything with Jim Parson), and spending time with her husband and children.  
Review of resident 17's activity documentation revealed:  
*A 6/29/18 progress note by the life enrichment director noted:  
-She had been offered several activities or social engagements but refused.  
-She was quite resistant to activities in the past but agreed to have chaplain visit.  
No other progress notes had been documented by the life enrichment director.  
*A 7/3/18 progress note by the chaplain noted she welcomed prayer and return visits.  
No other progress notes had been documented by the chaplain.  
*From 5/13/19 to 6/12/19 her activity log noted TV daily, one day with visitor, and one day with an outing.  
Interview on 6/11/19 at 3:30 p.m. with the life enrichment director revealed:  
*Resident 17:  
-Had refused to have the activity calendar in her room.  
-Had been offered the painting classes but had
BETHANY HOME - BRANDON

3012 E ASPEN BLVD
BRANDON, SD 57005

F 679  Continued From page 9
refused them.
-Wanted to stay in her room.
*She had visited with her one to one but had not
documented those visits.
*Documentation of activity progress notes and
interventions could have been better.
*There were no other staff members to assist her
with activities.
*She also oversaw the restorative program.

Review of the provider's undated Purpose of the
Activity Program policy revealed:
"""The purpose of the Activity program is to
provide a planned schedule of recreational,
social, and other useful activities for the nursing
home resident designed to make life more
meaningful; to stimulate residents to their fullest
potential; to enable them to maintain a sense of
usefulness and self-respect."
"""The program offers: Sensory stimulation,
intellectual stimulation, memory stimulation,
spiritual stimulation, social stimulation and offers
opportunities for use of motor skills, creative
skills, and self-esteem skills."
"""The facility must provide for an on-going
program of activities designed in accordance with
the comprehensive assessment, the interest, and
the physical, mental, and psychosocial wellbeing
of each resident."

F 686  Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)
§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a
resident, the facility must ensure that
(i) A resident receives care, consistent with
professional standards of practice, to prevent

07/09/2019
Continued From page 10

Pressure ulcers and does not develop pressure ulcers unless the individual’s clinical condition demonstrates that they were unavoidable; and

(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

This REQUIREMENT is not met as evidenced by:

Surveyor: 32332

Based on observation, record review, interview, and policy review, the provider failed to have interventions in place to prevent the development of a pressure ulcer for 1 of 2 sampled residents (4) with pressure ulcers. Findings include:

Observation and interview on 6/11/19 at 8:20 a.m. with registered nurse (RN) B while providing wound care to a pressure ulcer on resident 4’s left heel revealed:

- A pressure ulcer to her left heel.

- The area on her heel was open and covered a large portion of the bottom of her heel.

RN B stated:
- The area on her heel was open at the time it was identified on 4/1/19.
- The hospice provider had changed the wound care orders about two weeks ago.
- The wound had been improving before the wound care orders had changed.
- The nurses change the dressing daily.
- The hospice nurse will observe the dressing change.
- The wound nurse (RN C) measured the wound.

Review of resident 4’s medical record revealed she was admitted on 2/21/19 from the hospital after a fall at her previous home.
Continued From page 11
*Her 2/21/19 admission skin assessment had indicated:
- Her skin color was normal, and skin temperature was warm.
- The skin turgor had not been documented.
- A bruise to her left eye.
- A scab to her left knee.
- No other skin concerns were identified.

*A 2/21/19 Braden Scale for Predicting Pressure Sore Risk revealed a score of 11, indicating she was at high risk for developing a pressure ulcer. Items identified were:
- Slightly limited sensory perception.
- Her skin was often, but not always moist.
- She was chairfast.
- Her mobility was very limited. She made only occasional slight changes in her positioning, but was unable to do frequent or significant changes independently.
- Her nutrition was very poor.
- Skin friction and shearing was a problem. She required moderate to maximum assistance with moving, and required frequent repositioning with maximum assistance.

A 2/28/19 Admission Minimum Data Set (MDS) assessment revealed she:
* Required extensive assistance of two staff for bed mobility, transfers, dressing, and hygiene.
* Did not walk.
* Was totally dependent on one staff person for locomotion.
* Tolled with extensive assistance of one.

The 2/28/19 MDS assessment, section M (skin) revealed she:
* Was at risk for developing a pressure ulcer.
* Did not have pressure areas.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
BETHANY HOME - BRANDON

**STREET ADDRESS, CITY, STATE, ZIP CODE**
3012 E ASPEN BLVD
BRANDON, SD 57005

**ID PREFIX TAG**
F 686

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

- Continued From page 12
- *Had a pressure reducing device to her chair and bed.*
- *Was not repositioned by staff.*

The 2/28/19 MDS Pressure Ulcer Care Area Assessment (CAA) indicated:
- *She had a potential for skin breakdown due to:*
  - Her inability to change positions adequately.
  - Requiring assistance with bed mobility.
- *Extrinsic factors:*
  - Had been identified for pressure: *"Needs special mattress or seat cushion to reduce or relieve pressure.*
  - Had not been identified for the need to reposition the resident on a regular turning schedule.
- *She did not have a pressure ulcer.*
- *Staff would monitor the resident and note any changes.*

Review of resident 4's 2/22/19 initial care plan:
- *Had not included the risk of skin concerns.*
- *Had identified she required extensive assistance of two staff and a mechanical stand lift for transfers.*

Review of the 3/1/19 hospice skilled nursing admission assessment revealed:
- *A Braden Scale score of 13, indicating moderate risk for pressure ulcers related to:*
  - Chairfast.
  - Very limited mobility.
  - Very poor nutrition.
  - Friction/Shear problem.
- *A Palliative Performance Scale indicated a score of forty percent related to:*
  - Mainly sit to lie.
<table>
<thead>
<tr>
<th>(X4) ID</th>
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<tr>
<td>F 686</td>
<td>Continued From page 13</td>
<td>F 686</td>
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<td></td>
<td>• Self care: Total care.</td>
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<td>• The hospice admission assessment had not included a skin assessment.</td>
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<td>Review of the 3/1/19 hospice interdisciplinary care plan revealed:</td>
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<td>• A hospice aide was to visit the resident five times every week for twelve weeks, then three times every week for one week.</td>
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<td>• Aide duties were to have included repositioning and personal care including skin care.</td>
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<td>• A hospice nurse was to have visited twice weekly for twelve weeks, then once weekly for one week.</td>
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<td>• Nurse duties had included assessing her skin condition.</td>
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<td>Review of resident 4's 2/21/19 through 3/29/19 interdisciplinary progress notes regarding skin concerns revealed:</td>
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<td>• Seventy-two hour nursing assessments completed on 2/22/19, and 2/24/19 identified an abrasion to her knee and a bruise to her eye.</td>
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<td>• A Significant change in Condition Nutritional Assessment indicated a Braden Scale score of 11, “Very high risk for skin breakdown.” A Mighty Shake was added for additional protein.</td>
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<td>• Full Skin Assessments completed 3/8/19, 3/15/19, and 3/22/19 indicated:</td>
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<td>• There were no new skin issues.</td>
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<td>• Her finger and toe nails were trimmed.</td>
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<td>• A Full Skin Assessment completed 3/29/19 her skin was clean, dry, and intact.</td>
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<td>A 3/1/19 Significant Change MDS assessment was completed due to the resident's admission to hospice with a diagnosis of senile degeneration of the brain. That MDS assessment indicated:</td>
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<td>• Section G:</td>
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<td>• The activities of daily living had only changed</td>
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F 686 Continued From page 14

with the resident's ability to assist with hygiene
with limited assistance of one staff.
- She continued to require extensive assistance
with the other areas.
* Section M (skin):
- There were no changes in the skin assessment.
- The resident was not repositioned by staff.

The 3/8/19 MDS Pressure Ulcer CAA:
* Had no newly identified concerns or treatments.
* Had not identified the need to reposition the
resident on a regular turning schedule.
* She did not have a pressure ulcer.
* Staff would monitor the resident and note any
changes.
* The pressure ulcer risk was to have been
addressed on her care plan to minimize the risk
of pressure ulcers.

There were no new interventions added to the
care plan at that time.

Review of the interdisciplinary progress notes on
4/11/19 revealed RN M documented:
* A five centimeter (cm) by (x) three cm stage
three pressure ulcer to resident 4's left heel.
"Wound bed is pink, no bleeding noted."
* A dressing was applied.
* The physician was faxed with the following
information: "Resident noted to have a Stage III
pressure ulcer to her left heel. Area measures 5 x
3 cm pink peri-wound with circular margins. Small
necrotic area to upper aspect.
* The physician approved wound care orders and
a Sage boot (for heel protection to minimize
pressure) at all times except transfers.

There was no documentation in the medical
record of a skin concern to resident 4's heel prior
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<td>F 686</td>
<td>Continued From page 15 to identifying the open wound on 4/1/19. A 4/4/19 Wound Integrity Evaluation was faxed to the physician indicating a 3 x 5 cm stage II pressure ulcer. *The wound had a depth of 0.2 cm. No tunneling or undermining. *The wound bed was &quot;Red 100%, Dermal Base (pink/red) Partial thickness.&quot; Periwound edges were macerated (soft/moist). &quot;Infection/critical Colonization: Localized s/s [signs and symptoms]; Non-healing: Systemic s/s: Exudate Increase, Erythema/Edema.&quot; Interview on 06/11/19 12:25 p.m. with RN wound nurse/neighborhood leader C regarding resident 4's pressure ulcer identified on 4/1/19 revealed: *RN B notified her of the pressure ulcer. *It was originally identified as a stage III ulcer by her, but the wound consultant (a dressing sales nurse) corrected the wound to stage II after he assessed it on 4/4/19. *The nurses were to have documented skin assessments weekly with the residents' baths. *Nothing had been identified on the heel until 4/1/19. *The resident's shoes were not appropriate; they had been too large and moved around on her feet. *She used the heal of her foot to push/propel her wheelchair and wandered about the neighborhood. *The friction from pushing with her heel, and laying in bed were the probable causes of the pressure ulcer. *The seat cushion and standard pressure relieving mattress had been in place to prevent skin breakdown. *She stated there was a lack of documentation.</td>
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| F 686             | Continued From page 18...  
|                   | *She confirmed no other preventative measures had been in place prior to the identification of the pressure ulcer.  
|                   | *After the ulcer had been identified interventions added included:  
|                   | - A Sage boot was applied to the left foot.  
|                   | - Daily dressing changes.  
|                   | - Repositioning at least every 2 hours.  
|                   | *Nutrition interventions including Arginoid protein, whole milk, Ensure, and fingerfoods.  
|                   | Review of the care plan after the pressure ulcer was identified on 4/1/19 revealed:  
|                   | *On 5/19/19 the dietary department included the Arginoid and Ensure for skin healing.  
|                   | *A pressure ulcer care plan was added on 4/1/19:  
|                   | - The goal was the pressure ulcer would show signs of healing and remain free from infection.  
|                   | - "Turn/reposition at least every 2 hours, more often as needed or requested."  
|                   | - "Pressure relieving/reducing device on bed/ chair."  
|                   | - On 8/4/19 an intervention of a Sage boot to her left foot was added.  
|                   | - On 8/4/19 an intervention to assess her skin weekly on her bath day and alert the physician of changes.  
|                   | Review of RN/wound nurse C's wound assessments requested by the surveyor revealed a one-page typed list:  
|                   | *4/2/19: Stage 3 (changed to a stage 2 per wound consultant: 5 x 3 cm.  
|                   | *4/12/19: Stage 2: 4 x 2 cm.  
|                   | *4/16/19: Stage 2: 4.5 x 3.5 cm.  
|                   | *4/24/19: Stage 2: 4 x 3.5 cm.  
|                   | *4/30/19: Stage 2: 3.4 x 2.5 cm.  

**Attention**: All references to "pressure ulcer" should be replaced with "pressure ulceration".
Continued From page 17

*5/7/19: Stage 2: 5 x 7 cm.
*5/14/19: Stage 2: 3 x 4 cm.
*5/21/19: Stage 2: 4 x 3 cm.
*5/28/19: Stage 2: 3 x 2 cm.
*6/4/19: Stage 2: 4 x 3 cm.

RN/wound nurse C's wound assessments:
*Only consisted of the length and width of the wound.
*Had not included wound depth measurements, except for the initial 4/4/19 assessment by the wound consultant.
*Had not included further documentation of undermining, tunneling, exudate, or symptoms of infection.

Review of the interdisciplinary progress notes, other nurses:
*Had documented drainage, maceration, "necrotic areas" or black spots.
*Some of that documentation included wound measurements.
*Some measurements had been documented in inches rather than centimeters.

Phone interview on 6/12/19 at 4:20 p.m. with hospice nurse D regarding resident 4's pressure ulcer care revealed:
*When asked about not assessing the resident's skin on admission the nurse provided no comment.
*She stated:
- The pressure area was not identified until 4/1/19.
- She did not assess the wound.
- She sometimes observed the wound care done by facility nurses.
- The pressure ulcer occurred rapidly.
- The resident had a seat cushion and a pressure relieving mattress.
F 686  Continued From page 18

- The facility did not allow low-air loss mattresses.
- Neither the provider nor the hospice provider had added other interventions, such as floating her heels on pillow support.

Interview on 6/12/19 at 3:45 p.m. with the director of nursing confirmed:
* Preventative measures were not added to the resident's plan of care until the pressure ulcer was identified.
* A correction/education with the staff was held after the ulcer had been identified.
* RN B had reported at that time she thought the resident's heel was soft or bogy the day before it was identified, but hadn't documented it.
* The wound nurse's measurements were not complete.

Review of the provider's reviewed March 2018 Prevention and Treatment of Skin Ulcers policy and procedure revealed:
* The purpose was to:
  - Identify residents at risk for skin breakdown in order to prevent breakdown.
  - Aggressively treat and heal skin issues by use of effective interventions.

* Prevention was to have included:
  - Identifying risk factors including decreased mobility, poor nutritional status, and a decreased level of consciousness.
  - A Braden Scale Assessment on admission, annually and with significant changes.
  - Establishing a care plan based on assessments.
  - A dietary nutritional assessment.
  - A repositioning and turning program.
  - Monitoring skin daily and providing moisturizers.
  - Providing pressure reducing cushions or mattresses.
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
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<th>Description</th>
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</table>
| F 686 | - | "Reducing pressure was to have included:  
- "Use devices such as pillows and foam wedges that totally relieve pressure on the heels [most often raising heels completely off the bed]."
- "Use positioning devices such as pillows or foam to prevent direct contact between bony prominences' [knees or ankles]."
- "Develop a written plan for the use of positioning devices as well as pressure reducing devices and techniques." |
| F 689 | SS=G | Free of Accident Hazards/Supervision/Devices  
CFR(s): 483.25(d)(1)(2)  
§483.25(d) Accidents. The facility must ensure that - |

**07/02/2019**

Interdisciplinary team met on Resident 17 on 07/01/2019 and agreed that Core Plan should continue to identify transfers for resident 17 should be performed by two staff members at this time. Resident is currently compliant with allowing use of seat belt in whirlpool. Resident has not had a whirlpool bath recently and has been receiving bed baths according to her preference. A referral was made to therapy to screen for bathing safety and transfers.

DON or designee will interview all residents/family/staff to identify...
F 689 Continued From page 20

§483.25(d)(1) The resident environment remains as free of accident hazards as is possible, and
§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:

Surveyor: 18560
Based on observation, interview, and record review, the provider failed to prevent injuries for one of one sampled resident (17) with major injury from a fall and for one of one sampled resident (29) with a burn. Findings include:

1. Observation from 6/10/19 through 6/12/19 of resident 17 revealed she was constantly laying on her back in her bed watching TV.

Review of resident 17’s medical record revealed:
*She had been admitted on 5/24/14.
*Her diagnosis included flaccid hemiplegia affecting her right dominant side, epilepsy, and morbid obesity.

Review of resident 17’s Minimum Data Set (MDS) assessments revealed:
*On her quarterly 12/21/18 assessment she was totally dependent on staff and required two staff member physical assistance for bathing.
*Had impairment on one side of her upper extremity.
*Had impairment on one side of her lower extremity.
*Had no pain.
*Had no falls.
*On her annual 3/22/19 assessment: her behavior status had gotten worse.
*Bathting had not occurred.

F 689

Residents’ preferred method of bathing and identifying any bathing safety concerns or precautions by 07/06/2019.

Care plans will be reviewed/designed to ensure bathing preferences and bathing safety by the DON or designee by 07/06/2019.

Education and training in the form of a Directed Intervene will be held by the DON on 07/02/2019 and 07/03/2019 for all facility staff about their roles and responsibilities for ensuring resident quality of care and quality of life relating to keeping residents free from accidental hazards, supervision, or restraint devices inclusive of Bathing Preferences and Bathing Safety.

Beginning 07/02/19 DON or designee will randomly audit 5 residents to assure bathing provided per preferences and bathing safety once a week for 12 weeks inclusive of, but not limited to, ensuring bath sets are being worn by all residents who use the whirlpool tub, whirlpool chairs are at proper levels, and that the residents are being transported per their care plan. DON or designee will report findings to the monthly QA_HAP committee for review and recommendations for frequency of ongoing monitoring and actions to be taken.

Whirlpool Bathing Policy reviewed with no changes and was reviewed and approved by the Bethany-Brandon QA/HAP committee on 08/28/2019.

Dietary Director or designee will consult with resident 29 on 06/27/2019 to ensure her hot liquid preferences and safety interventions are in her care plan. Resident 29 has not experienced any burns since the incident and a need to be assessed was performed on 06/27/2019 ensured that the burn on her leg was healing appropriately. A referral to occupational therapy was made for resident 29 for further assistance in meeting her safety needs. Interdisciplinary Team reviewed resident 29 on 07/01/2019 to do a lesson review of hot beverage safety. Care Plan updated with interventions to protect resident from hot liquids and the resident’s response.

All residents in the facility were reviewed by the Interdisciplinary team to identify those at risk for hot beverage injury starting 07/01/2019.

The interdisciplinary team evaluated each resident identified at risk for hot beverage injury and reviewed on 07/01/2019 and updated their care plans with interventions to prevent burns from hot liquids.

Beginning on 07/02/2019 the Dietary Director or designee will consult with resident identified at risk weekly x4, then monthly x3, to ensure compliance with the care plan for resident hot liquid preferences and safety. Dietary Director or designee will report findings to the QA/HAP committee monthly for review and recommendations for frequency of ongoing monitoring and further action to be taken.

On 05/20/2019 the QA/HAP committee approved the new Safety of Hot Liquids Policy developed by the interdisciplinary team. The Safety of Hot Liquids Policy and Procedure included identification of high risk residents and set parameters for coffee temperature.

A Directed Intervene will be held on 07/02/2019 and 07/03/2019 for Neighborhood Leader, Certified Dietary Manager, and all staff regarding their roles and responsibilities for ensuring resident quality of care and quality of life relating to keeping residents free from accidental hazards, supervision, or restraint devices.

Starting 07/01/2019 all cupboards on the neighborhoods will be closed to ensure residents who cannot safely access coffee cannot access the hot liquids.

Dietary Director or designee will audit coffee temperatures once a day for one week, and weekly x3 months to ensure coffee temperatures are between 160 and 140 degrees.

Dietary Director or designee will present the findings of the audit to the monthly QA/HAP committee who will review and make recommendations.
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<th>F 689</th>
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<tbody>
<tr>
<td></td>
<td>-She had impairment on one side of her upper extremity.</td>
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<td>-She had impairment on one side of her lower extremity.</td>
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<td>-She had moderate pain occasionally that limited her day-to-day activities.</td>
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<td>-She had a fall with major injury.</td>
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Review of resident 17's care plan revealed:

"Focus initiated on 10/13/17:
-"Have had a stroke causing me to be flaccid on the right side of my body."
-"I am at risk for falls and pressure ulcers."

*Interventions/tasks initiated on 3/11/19:
-"I do not like using the belt for the bath chair. I know the risks of not using this belt. Please offer to use the bath chair belt with each bath."
-"I like to have the bath chair raised high enough to where my feet do not touch the floor. Please keep the chair as low as possible for my comfort and to encourage safety."

*Interventions/tasks initiated on 3/15/19, "I suffered a fall on 3/2/19 from the bath-chair in spa room that resulted in a major injury of a broken right femur."

*Interventions/tasks revised on 3/24/19:
-"I require extensive 2 assist for bed mobility, dressing, toileting, hygiene, and bathing."
-"I require extensive assist x 2 with bathing."

Review of resident 17's 3/2/19 at 9:00 a.m. registered nurse (RN) progress note revealed:
-"Called into Spa room. Resident found lying on the floor tilting slightly to the left. Her head was by the tub. She was on her back and her right leg was bent at the knee and under her left leg. CNA [certified nurse aide] states resident was sitting on the bath chair and the CNA was drying her right arm. Resident suddenly slumped forward..."
Continued From page 22

and fell on the floor. The bath chair was in high position. Resident denies hitting her head. She is able to move her left arm and leg. Right extremities flaccid from old stroke. She denied having pain. A Hoyer lift was used to pick resident up and place her in her wheelchair. Resident returns to lying position in her bed. She flinches when her left leg and arm moved.

"When lying in bed, she flinched when her right extremities were moved."

"Resident transported to [hospital name] ER."

Review of resident 17's 3/2/19 fall report revised on 3/7/19 revealed:
*One staff member witnessed her fall.
*Initial cause note, "Resident went unresponsive and did not have bath belt on."
*Interventions, "Resident requests to not have bath belt on and requests to have bath chair at a higher level so her feet do not touch the floor. Will try educating resident on importance of bath belt and see if she will allow the bath belt to be on."

Review of resident 17's 3/14/19 physician's progress note revealed, "She slid out of a shower chair and fractured her femur. She underwent surgical repair. She ended up in the hospital for over a week."

Interview on 8/12/19 at 9:18 a.m. neighborhood leader/RN C confirmed resident 17 needed two staff members to assist with her bathing.

Interview on 8/12/19 at 11:00 a.m. with the director of nursing (DON) regarding resident 17's fall revealed:
*She had not liked the bath belt.
*She liked the chair up higher so her feet would not touch the ground.
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| F 689 |    |    | Continued From page 23<br>*The chair was up higher and she had an unresponsive episode.<br>*Two staff members had assisted her from her wheelchair to the bath chair.<br>*When she was in the tub there was only one staff member with her.<br>*When she moved from inside the tub to outside the tub still on the bath chair she would only expect one staff member to assist.<br>*When she moved from the bath chair back to her wheelchair after the bath she expected two staff members to assist.<br>*After her fall, she agreed to use bath belt and not to have the chair so high.<br>Continued interview on 6/12/19 at 11:30 a.m. with the DON confirmed:<br>*Moving a resident from inside the tub to outside the tub while still on the bath chair was considered a transfer.<br>*With resident 17's diagnoses, her refusal to use the bath belt, and her wanting the chair higher, two staff members should have assisted her with the transfer in and out of the bath tub. 2. Review of resident 29's medical record revealed:<br>*She had been admitted on 11/2/15.<br>*Her diagnoses included diabetes, Parkinson's disease, and dementia with lewy bodies. Review of resident 29's MDS assessments revealed:<br>*On her 7/10/18 significant change assessment:<br>-Her Brief Interview for Mental Status (BIMS) score had been five that indicated her cognition was severely impaired.<br>-The inattention behavior was present and fluctuated day to day.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

435130

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
08/12/2019

NAME OF PROVIDER OR SUPPLIER
BETHANY HOME - BRANDON

STREET ADDRESS, CITY, STATE, ZIP CODE
3012 E ASPEN BLVD
BRANDON, SD 57005

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

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| F 689         | Continued From page 24
-She needed extensive assistance from one staff member for eating and drinking.
-On her 4/15/19 quarterly assessment:
-Her BIMS score had been a two that indicated her cognition was severely impaired.
-The inattention behavior was present and fluctuated day to day.
-The disorganized thinking behavior was present and fluctuated day to day.
-She needed extensive assistance from one staff member for eating and drinking.

Review of resident 29's care plan revealed:
*Focus area revised on 11/13/17 noted she had impaired visual function related to cataracts and diabetic retinopathy.
*Focus area revised on 2/7/19 noted she had poor vision.
*Interventions/tasks revised 3/25/19 noted she needed assistance with eating.

Review of resident 29's health status notes revealed:
-On 4/26/19, "Was noted during bath resident has a two inch by one inch partially intact blister in right inner thigh. Unsure of cause. Will monitor."
-On 5/2/19, "Resident seen during physicians round this morning. New order to apply house banner cream to blistered area of right upper inner thigh with each brief change."
-On 5/6/19,
-"When doing rounds, resident noted to have eight by two cm [centimeters] burn-like area to her right inner thigh."
-"Consistent with resident dropping hot liquids such as coffee or hot chocolate which is not uncommon as resident has diagnosis of Parkinson's Disease."
Continued From page 25
Review of resident 29's 5/6/19 notification to physician form noted, "Resident noted to have burn-like abrasion to her Rt [right] inner thigh. Resident will often tumbler with drinks et [and] may have split coffee or hot chocolate in her lap. Area measures 8 x 2 cm with slough to peri-wound."

Interview on 6/12/19 at 2:45 p.m. with neighborhood leader/registered nurse (RN) C, neighborhood leader/RN G, and RN L regarding:
* Coffee and hot chocolate:
  - Residents were able to have coffee and/or hot chocolate any time.
  - They would prefer residents ask for assistance with coffee and/or hot chocolate.
  - Nursing staff had not monitored the temperature of the coffee.
  - Thought coffee mug lids had been ordered.
* Resident 29:
  - She drank a lot of coffee.
  - Confirmed there was a coffee spill on her inner thigh.
  - Had ice added to her coffee since the coffee spill.
  - Since the spill they have been trying to have someone sit with her while she drinks her coffee.

Interview on 6/12/19 at 4:12 p.m. with the DON regarding resident 29 revealed:
* She liked her coffee.
* She often had trouble tipping the coffee up to her mouth or may have gotten sleepy at the table.
* She was unable to get her own coffee.
* Since the spill they tried to cool down her coffee.

Interview on 6/12/19 at 4:40 p.m. with the certified dietary manager regarding coffee revealed:
* Residents were able to serve themselves.
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</table>
| F 689  | Continued From page 26  
*The dietary department had not monitored the coffee temperature.  
*Disposable coffee mug lids were available on the neighborhoods.  
*She expressed concern the disposable lids were a dignity issue.  
*They were researching a more dignified coffee mug.  
Further interview on 6/12/19 at 4:45 p.m. with the DON confirmed:  
*They had been researching coffee mugs with lids.  
*They had not completed hot beverage assessments.  
*They had no policy related to hot beverages. | F 689  | F 880  
Resident 4 and all residents are at risk if proper infection control techniques are not maintained during dressing changes, therefore:  
The Dressing Change Policy and Application of Topical Medication was reviewed with no changes recommended by the ICT on 06/26/2019 and also by the QAPI committee on 06/26/2019.  
A Directed Inservice Training will be provided on 07/02/2019 and 07/03/2019 by the DON to RN B, all licensed nurses, and all staff regarding their roles and responsibilities for ensuring resident quality of care and quality of life relating to Infection Prevention and Control, specifically the Dressing Change Policy and Topical Medication Policy, including the need to use a new cotton-tipped applicator each time the tip of the applicator is touched.  
The DON and facility skin nurse will conduct competency testing on Dressing changes and Topical Medication Administration for all Licensed Nurses by 07/02/2019.  
Beginning 07/02/2019 DON or designee will randomly audit 5 dressing changes or topical medication application weekly for 12 weeks to ensure compliance with the Dressing Change and Topical Medication Policy.  
DON or designee will present the findings of the audit to the QAPI committee monthly for review and recommendations for action to be taken.  
Interdisciplinary team reviewed the Policy and Procedures for Whitewood cleaning on 06/26/2019. Manufacturer's recommendations were included in the Policy. No changes were made and the QAPI committee approved the continuation of the policy without changes on 06/26/2019.  
A Directed Inservice will be held on 07/02/2019 and 07/03/2019 for CHA J, CNA K, Neighborhood Leader C, CNA L and all staff regarding their responsibilities for ensuring resident quality of care and quality of life relating to Infection Prevention and Control. Specifically in the area of proper whitewood cleaning techniques. | 07/09/2019 |
| F 880  | F 880  
Resident 4 and all residents are at risk if proper infection control techniques are not maintained during dressing changes, therefore:  
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A Directed Inservice will be held on 07/02/2019 and 07/03/2019 for CHA J, CNA K, Neighborhood Leader C, CNA L and all staff regarding their responsibilities for ensuring resident quality of care and quality of life relating to Infection Prevention and Control. Specifically in the area of proper whitewood cleaning techniques. | 07/09/2019 |

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NAME OF PROVIDER OR SUPPLIER  
BETHANY HOME - BRANDON  

(04) ID PREFIX TAG | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |
|------------------|-----------------------------------------------|
| F 689            | Continued From page 26  
*The dietary department had not monitored the coffee temperature.  
*Disposable coffee mug lids were available on the neighborhoods.  
*She expressed concern the disposable lids were a dignity issue.  
*They were researching a more dignified coffee mug.  
Further interview on 6/12/19 at 4:45 p.m. with the DON confirmed:  
*They had been researching coffee mugs with lids.  
*They had not completed hot beverage assessments.  
*They had no policy related to hot beverages.  

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 (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
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| F 880  | Continued From page 27
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 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
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X1) PROVIDER/SUPPLIER/CIA. IDENTIFICATION NUMBER:</th>
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<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
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**NAME OF PROVIDER OR SUPPLIER**

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

| 3012 E ASPEN BLVD |
| BRANDON, SD 57005 |

**SUMMARY STATEMENT OF DEFICIENCIES**

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<td>F 880</td>
<td>Continued From page 28 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: 32332 Based on observation, record review, interview, and policy review, the provider failed to ensure proper infection control techniques were maintained for: *One of three (4) observed dressing changes. *Two of two observed whirlpool tub cleanings. Findings include: 1. Record review of resident 4's medical record revealed she had a stage two pressure ulcer to her left heel. Observation on 6/11/19 at 8:20 a.m. with registered nurse (RN) B during dressing change to resident 4's heel wound revealed RN B: *Disinfected the bedside table and set up the dressing supplies. *Appropriately washed her hands and put on gloves. *Opened a tube of Medihoney (a wound ointment) and dipped a cotton-tipped applicator onto the tip of the Medihoney tube. *Applied the Medihoney to the resident's heel ulcer. She then: *Squeezed the tube and dipped the same cotton-tipped applicator onto the tip of the Medihoney tube to load the applicator. *Applied that ointment onto the wound. With the same applicator she: *Dipped the applicator for a third time onto the tip of the wound ointment and applied that to the...</td>
<td>F 880</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** BETHANY HOME - BRANDON

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 3012 E ASPEN BLVD BRANDON, SD 57005

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| F 880 | Continued From page 29 heel wound.  
*Covered the wound with a dressing and washed her hands.  
Interview on 06/12/19 4:45 p.m. with the DON regarding resident 4's dressing change confirmed RN B should have used a new applicator each time she touched the tip of the ointment tube to apply the Medihoney to the resident's wound.  
Review of the provider's September 2014 Non-sterile Dressing Change policy revealed:  
*The purpose was to define a procedure for performing non-sterile dressing changes according to infection control regulation requirements.  
*The procedure had indicated the staff member was to have:  
-Washed hands and put on a clean pair of gloves.  
-Cleaned the wound according to the physician's order.  
-Dressed the wound according to the physician's order.  
-Secured the dressing according to the physician's order.  
-Document the procedure and wound appearance in the resident's chart.  
*The procedure had not mentioned reusing soiled applicators to reapply wound ointments.  
Surveyor: 36413  
b. Observation and interview on 6/11/19 at 3:36 p.m. with certified nursing assistant (CNA) J while cleaning the whirlpool tub revealed:  
*She added the disinfectant to the water, by pushing a button.  
*The tub was marked for accurate measurement of the water and disinfectant mixture.  
*She scrubbed the tub and left it to sit for ten
F 880 Continued From page 30 minutes.
*She agreed the sides of the tub and the chair were dry after ten minutes.
*She rinsed out the tub and the jets.
*She was not aware the manufacture's instructions were to keep it all wet for ten minutes.

Observation and interview on 6/12/19 at 11:00 a.m. with CNA K revealed:
*She added the water and disinfectant per policy.
*She let the tub stand for ten minutes.
*She was not aware she needed to keep it wet for ten minutes.

Interview on 6/12/19 at 10:31 a.m. with neighborhood leader G revealed:
*She was the infection control nurse.
*She was not aware the tub would have to stay wet for ten minutes.

Interview on 6/12/19 at 11:11 a.m. CNA I revealed she:
*Trained new certified nurse assistants.
*Trained them to clean the whirlpools.
*Did not keep the whirlpool wet for ten minutes.
-Staff would have scrubbed with a brush to ensure everything was wet and then let it set for ten minutes.
-Then return and finish procedure.

Review of the sign on the whirlpool tub revealed "Leave disinfectant on for 10 minutes when cleaning."

Review of the provider's procedure for Cleaning the Whirlpool Bathtub revealed:
*This was posted near the whirlpool.
*Step 6 read: Let the disinfectant stay on the
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<tr>
<td>F 880</td>
<td>Continued From page 31 surfaces for ten minutes.</td>
<td>F 880</td>
<td>Review of the manufacture's instructions for the whirlpool disinfectant revealed: *Apply to hard, nonporous surfaces, thoroughly wetting the surfaces. *Treated surfaces must remain wet for ten minutes.</td>
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E 000 Initial Comments

Surveyor: 35413
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 6/10/19 through 6/12/19. Bethany Home - Brandon was found in compliance.
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| K 000 INITIAL COMMENTS | Surveyor: 36413  
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/12/19. Bethany Home - Brandon 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, K223, and K521 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 222 Egress Doors  
SS=B CFR(s): NFPA 101 | 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, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6  
SPECIAL NEEDS LOCKING ARRANGEMENTS | K 222 | K222: Maintenance Director updated the lock on the egress door as Custerwood Court on 05/05/2020 after the surveyor noticed the door was not open.  
Maintenance Director or designee will audit the egress doors open properly once a year or less once a month.  
Maintenance Director or designee will present the findings of the audit to the QA committee, at the monthly meeting, who will provide further review and recommendations. | 07/04/2020 |

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

**Title**

**Date**

**Administrator**

**Date**

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 patient. **Exception: Long Term Care Facilities**
<table>
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<td><strong>Continued From page 1</strong>&lt;br&gt; Where special locking arrangements for the safety needs of the patient are used, all of the 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.&lt;br&gt;18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4&lt;br&gt;<strong>DELAYED-EGRESS LOCKING ARRANGEMENTS</strong>&lt;br&gt;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.&lt;br&gt;18.2.2.2.4, 19.2.2.2.4&lt;br&gt;<strong>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</strong>&lt;br&gt;Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.&lt;br&gt;18.2.2.2.4, 19.2.2.2.4&lt;br&gt;<strong>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</strong>&lt;br&gt;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.</td>
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN
B. WING

(X3) DATE SURVEY COMPLETED 06/12/2019

NAME OF PROVIDER OR SUPPLIER BETHANY HOME - BRANDON

STREET ADDRESS, CITY, STATE, ZIP CODE 3012 E ASPEN BLVD BRANDON, SD 57005

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE

| K 222 | Continued From page 2 18.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Surveyor: 40508 Based on observation, testing, and interview, the provider failed to provide egress doors as required at one of seven locations (staff entrance to the sun room). Findings include: 1. Observation at 8:00 a.m. on 6/12/19 revealed the exterior exit door for the staff entrance to the sun room was equipped with magnetic lock hardware that prevented egress. The door was labeled as a delayed egress locked door. Testing of the door by applying force in the direction of the path of egress revealed the audible signal would not sound. The required irreversible process of unlocking the door had not initiated. Interview at the time of the observation with the maintenance supervisor confirmed that condition. He was unaware of the condition when it was discovered. He further stated the release of the magnetic door locks were checked and documented on a monthly basis. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one of seven exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.9.2(3)(a) K 222 | K 222 | | |
| K 223 | Doors with Self-Closing Devices SS=C CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure. | | | | 07/02/2019 |
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| K 223               | Continued From page 3  
or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:  
* Required manual fire alarm system; and  
* Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and  
* Automatic sprinkler system, if installed; and  
* Loss of power.  
18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 40506  
Based on observation and interview, the provider failed to maintain one randomly observed facility cooking area pair of doors and one pair of required fire doors (Cottonwood Court cross-corridor fire doors) as required. Findings include:  
1. Observation at 8:45 a.m. on 6/12/19 revealed the kitchen was not protected as required. The automated corridor doors from that room were in a required smoke barrier. The pair of doors revealed a gap of one-half inch.  
Reference NFPA 19.3.2.5.3 requiring a smoke barrier when the cooking facility serves greater than 30 persons.  
Interview with the maintenance supervisor at the time of the observation confirmed that finding.  
The deficiency affected one of numerous requirements for cooking facilities and had the potential to affect 100% of the occupants of that... | K 223 | | |
K 223 Continued From page 4

smoke compartment.

2. Observation at 11:15 a.m. on 6/12/19 revealed the cross-corridor pair of ninety-minute fire doors leading to Cottonwood Court had not closed and latched when released from the magnetic hold-opens.

Interview with the maintenance supervisor at the time of the observation confirmed that finding. He further stated air pressure differentials made it difficult to assure the doors were closed.

The deficiency affected one of five sets of cross-corridor fire doors and had the potential to affect 100% of the occupants of two smoke compartments.

K 521 HVAC

SS=C CFR(s): NFPA 101

HVAC

Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer’s specifications.

18.5.2.1, 19.5.2.1, 9.2

This REQUIREMENT is not met as evidenced by:

Surveyor: 40506

Based on observation and interview, the provider failed to add HVAC systems as necessary (long storage room). Findings include:

1. Observation at 9:55 a.m. on 6/12/19 revealed
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| K 521         | Continued From page 5  
the long storage room was not correctly provided with space conditioning. The space was provided with six flanged openings, each sized approximately twelve inches by eighteen inches, to the space above the corridor ceiling. The openings allowed the sprinkler pipes within the storage space to be protected from cold temperatures.  
Interview with the maintenance supervisor gave acknowledgement of the openings when the deficiency was identified. He was unaware the storage area could not be supplied conditioned air from the corridor plenum.  
Failure to provide HVAC systems as required increases the risk of death or injury due to fire.  
The deficiency had potential to affect all residents within the smoke compartment. | K 521 | | |
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| S 000 | Compliance/Noncompliance Statement
Surveyor: 36413
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/10/19 through 6/12/19. Bethany Home - Brandon was found in compliance. | S 000 |
| S 000 | Compliance/Noncompliance Statement
Surveyor: 36413
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 6/10/19 through 6/12/19. Bethany Home - Brandon was found not in compliance with the following requirement: S0035. | S 000 |
| S 035 | 44:74:02:07 Approval and Reapproval of Training Programs
The department must shall approve nurse aide training programs. To obtain approval, the entity providing the nurse aide training program shall submit to the department an application on a form provided by the department that contains information demonstrating compliance with requirements specified in this chapter. The department shall respond within 90 days after receipt of the application. The department may grant approval for a maximum of two years.

At the end of the approval period, the entity shall apply for reapproval. As part of the reapproval process, the department shall conduct an unannounced on-site visit to determine compliance with the requirements. | S 035 |
| S035 | Bethany's Human Resources Director updated the training form to reflect that R.N.A was the program coordinator and primary instructor.
The new form was approved by the South Dakota Board of Nursing on 09/21/2010. HR Director will monitor that the South Dakota Board of Nursing form is updated on an annual basis when the form expires. HR Director will present the findings of the audit to the QA/PI committee, when the next annual review of the form is due, who will provide further review and recommendations. | 07/09/2019 |

Hannah Winklepleck
Administrator
07/03/2019
This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 32332
Based on the provider's Nurse Aide Training Program (NATP) application and interview, the provider failed to notify the South Dakota Board of Nursing (SD BON) of changes in the NATP coordinator and primary instructor within thirty days after the change. Findings include:

1. Interview and review on 6/12/19 at 3:15 p.m. with the director of nursing (DON) of their NATP application revealed:
*The application had listed RN D as the program coordinator and the primary instructor.
*The DON stated:
-RN D was no longer the program coordinator or primary instructor of the NATP.
-RN A had replaced RN D as the coordinator and primary instructor for the NATP in June 2018.
*The DON stated she was not aware she needed to notify the SD BON of any changes in the NATP.