

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

ORIGINAL

PRINTED: 04/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/13/2016
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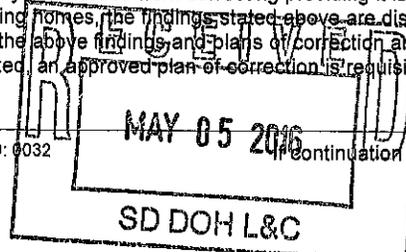
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401
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F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/11/16 through 4/13/16. Bethesda Home of Aberdeen was found not in compliance with the following requirement(s): F176, F226, F250, F281, F309, F323, F431, and F441. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/11/16 through 4/13/16. Areas surveyed included dietary and nursing services. Bethesda Home of Aberdeen was found in compliance.	F 000	*Addendums noted with an asterisk per 5/18/16 per telephone with facility administrator and DON. CS/SPDOH/EL	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and policy review, the provider failed to ensure physicians' orders and assessments for self-administration of nebulizer (for breathing) medication were completed for two of two randomly samples residents (14 and 18). Findings include: 1. Observation and interview on 4/12/16 at 7:45 a.m. in resident 18's room with registered nurse (RN) I revealed:	F 176		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce Johnson</i>	TITLE Administrator	(X6) DATE May 4, 2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 176	<p>Continued From page 1</p> <p>*The resident had an order for a nebulizer treatment.</p> <p>*She set-up the nebulizer machine up for use and began the treatment.</p> <p>*She stated she would return in ten minutes. That was her normal way of doing nebulizer treatments.</p> <p>*The resident was left in his room with the nebulizer on.</p> <p>Further observation on 4/12/16 at 7:56 a.m. revealed RN I returned to resident 18's room. She turned off, disconnected, and cleaned the nebulizer equipment.</p> <p>2. Observation and interview on 4/12/16 at 9:30 a.m. in resident 14's room, with registered nurse (RN) H revealed:</p> <p>*The resident had a physician's order for a nebulizer treatment.</p> <p>*She set-up the nebulizer machine for use and began the treatment.</p> <p>*She stated she would return in about ten minutes. That was her normal way of doing nebulizer treatments.</p> <p>*The resident was left in his room with the nebulizer on.</p> <p>Interview on 4/13/16 at 3:15 p.m. with the director of nursing revealed:</p> <p>*They had not been considering a nebulizer left running in a resident's room as self-administration of the medication.</p> <p>*They had not been doing assessments to see if the resident was able to understand the reason for the nebulizer treatment and physically able to perform the steps needed.</p> <p>*They had not been requesting a physician's order for self-administration of a medication for</p>	F 176	<p>F176 (1,2,3)</p> <p>This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to residents #14 or #18. The policy for Bedside Meds/ Self Administration of Medication has been reviewed and revised. Assessments have been completed on all residents currently receiving medications through a nebulizer to determine if they are able to self-administer. Any Resident receiving an order for nebulizer treatments will have assessments completed to determine if they are able to self-administer the treatment. The Director of Nursing will review this deficiency and educate all nurses and med aides at in-service training to be held on May 10, 2016 and May 11, 2016. The Director of Nursing or her designee will audit residents who are receiving nebulizer treatments. Two residents will be monitored each week for 4 weeks and then monthly thereafter until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	5-12-16
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F 176	Continued From page 2 nebulizer treatments. 3. Review of the provider's undated Nebulizer Treatments Basic Responsibility form revealed: *The purpose was to safely administer medication through a nebulizer. *The medication was to have been set-up for the resident and turned on. *Upon completion of the treatment the nebulizer was to be turned to the off position, and the used parts were to be cleaned. *There was no directions to stay with the resident to ensure the medication was all received. Review of the provider's undated Bedside Medications policy revealed: *The care conference team was to have approved all bedside (self-administered) medications. *A physician's order was to have been obtained for medications at the bedside. *There was to have been monitoring of the resident's use of the medication. *Appropriateness of bedside medications was to be reviewed at least quarterly.	F 176			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335	F 226			

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F 226	<p>Continued From page 3</p> <p>Based on record review, interview, and policy review, the provider failed to ensure unwitnessed falls were investigated and documented for one of two sampled residents (3) with cognitive impairment (memory). Findings include:</p> <p>1. Review of resident 3's medical record revealed she had: *Fallen on 12/17/15, 1/4/16, and 2/26/16. *Those falls had not been witnessed. *Her thinking ability was severely impaired according to her Brief Interview for Mental Status interview.</p> <p>Review of resident 3's 12/17/15 accident/incident report revealed: *Her husband had found her on the floor and informed staff. *She had a cut to her forehead. *The section of the form titled "describe the incident" had "see attached" written on the lines. *The question was the care plan followed had been checked yes.</p> <p>Review of the attached 12/17/15 interdisciplinary note regarding resident 3 revealed: *The husband had notified staff she had fallen. *He had gone to use the resident's bathroom, and when he had come out she was on the floor. *She had hit her head and was bleeding. *The recliner had been in the normal sitting position according to the husband. *The call light was within reach but not on. *She had her shoes on. *There was no documentation regarding: -Who had been working on that hall during the time of the fall. -When she had last been assisted to the bathroom.</p>	F 226	F226 (1)	
			<p>This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to resident #3. The policy and procedure for Accident/Incident Reporting and Investigating has been revised. The policy will include more thorough investigation at the time of an accident/incident. The Director of Nursing will review this deficiency and education will be given to all nurses at in-service training to be held on May 10, 2016 and May 11, 2016. The Director of Nursing or her designee will audit that all Accidents/Incident Reports are complete and will educate individually if needed. Reviews will continue until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	5-12-16

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F 226	<p>Continued From page 4</p> <p>-If she had a decline in her health. *There had been no staff interviews conducted.</p> <p>Review of resident 3's 1/4/16 accident/incident report revealed: *She was found on the floor sitting on her bottom in front of her recliner. *The question was the care plan followed had been checked no. *There was no documentation of how the care plan had not been followed.</p> <p>Review of the attached 1/5/16 interdisciplinary note regarding resident 3 revealed: *The husband had informed staff he had left the room, and when he returned she was found on the floor. *There was no documentation regarding: -How or why the care plan was not followed. -Who had been working on that hall during the time of the fall. -When she had last been assisted to the bathroom. -If she had a decline in her health. *There had been no staff interviews conducted.</p> <p>Review of resident 3's 2/26/16 accident/incident report revealed: *She had been found lying on her left side on the floor at 3:30 a.m. *She was alert and able to move all extremities (limbs).</p> <p>Review of the attached 2/26/16 interdisciplinary note regarding resident 3 revealed: *She was found on the floor by the registered nurse on duty. *Her call light was on. *There was no documentation regarding:</p>	F 226		

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F 226	Continued From page 5 -How long the call light had been on. -Who had been working on that hall during the time of the fall. -When she had last been assisted to the bathroom. -If she had a decline in her health. *There had been no staff interviews conducted. Interview on 4/13/16 at 2:00 p.m. with the director of nursing revealed there was no more documentation regarding the above mentioned investigations. She was unsure how the care plan would not have been followed regarding the 1/4/16 incident. She thought it had been marked by mistake. Review of the provider's 1/17/13 Resident Accidents/Incident Reporting policy revealed: *An investigation of the incident would be completed by the nurse. *It should have included the circumstances surrounding the accident/incident and any pertinent facts as appropriate.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, record review, interview, job description review, and policy review, the	F 250		

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F 250	<p>Continued From page 6</p> <p>provider failed to ensure one of three sampled residents (10) who showed signs of depression received medically related social services. Findings include:</p> <p>1. Random observations of resident 10 from 4/11/16 in the afternoon, during the day on 4/12/16, and in the morning of 4/13/16, and interview on 4/12/16 at 10:30 a.m. of resident 10 revealed he:</p> <p>*Spent most of his time in his room either watching television or sleeping in his bed. *Did not participate in any group activities.</p> <p>Interview on 4/12/16 at 9:30 a.m. of resident 10 revealed he:</p> <p>*Missed his wife of sixty-three years who had died in 2014. *Said repeatedly he felt like his time here had dragged on. *Spoke very slowly and had a delayed response to asked questions.</p> <p>Review of resident 10's entire medical record revealed:</p> <p>*He had been admitted on 10/5/15. *On 11/27/15 he fell during a self-transfer and had fractured his hip.</p> <p>Review of resident 10's following social services assessments revealed in the two weeks prior to the date listed at least two to six of those days he had felt the following:</p> <p>*10/8/15 at admission: -He felt down, depressed, or helpless. -His family had explained to the staff his wife had done everything for him. "She died in July 2014 right after moving to [name of assisted living]." --They felt he had been depressed ever since.</p>	F 250	<p>F250 (1)</p> <p>This deficiency has the potential to affect all residents. The Licensed Social Worker and the Quality Care Team met on May 2, 2016 to Review Resident #10 to ensure there were no further negative outcomes. On May 2, 2016 the Licensed Social Worker and the Resident Care Coordinator visited with Resident #10 and his son/POA in regard to offering individual counseling or a referral to a Mental Health Consultant. Additional support through his spiritual home was offered. Social Service staff will audit all residents who show signs and symptoms of depression through comments made during the PHQ9 part of the quarterly interview or 1/1 visits, changes in lifestyle/environment, losses etc. Social services will visit with these residents and/or family in regard to offering Mental Health Services. Social services will update the Care Plan to reflect needed approaches/interventions including other disciplines as necessary.</p>	5-12-16

The SS mood policy was enhanced to include residents with life changing events. CS/SOC/1/16

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F 250	<p>Continued From page 7</p> <p>-His depression score was one out of ten, indicating minimal depression.</p> <p>*12/7/15:</p> <p>-He felt "hopeless," and when asked why said "I miss my wife."</p> <p>-He felt tired and had little energy.</p> <p>-He had trouble concentrating sometimes.</p> <p>-His depression score was seven indicating mild depression.</p> <p>*2/11/16:</p> <p>-He felt down, depressed or helpless, and he had stated "Depressed sometimes. I feel trapped sometimes."</p> <p>-He had little energy sometimes.</p> <p>-He moved or spoke slowly.</p> <p>-His depression score was five indicating mild depression.</p> <p>*2/18/16:</p> <p>-He felt hopeless because of how he was doing.</p> <p>-He had little energy and moved slowly.</p> <p>-His depression score was eight indicating mild depression.</p> <p>Review of resident 10's interdisciplinary notes from his admission on 10/8/15 through 4/12/16 revealed there was no documentation of any social services follow-up to his mood and expressions of feeling hopeless.</p> <p>Review of resident 10's 12/14/15 care plan revealed it had not addressed any mood concerns.</p> <p>Interview on 4/13/16 at 8:00 a.m. with the social worker and the social services director regarding resident 10 revealed:</p> <p>*They usually met with residents who scored a ten or higher on their mood assessment.</p> <p>*They had not visited with him about his</p>	F 250	<p>F 250 (cont)</p> <p>Social services will visit with Residents who are showing signs and symptoms of depression monthly for 3 months or longer if indicated by the Residents mood or circumstances.</p> <p>Social Services will report weekly to the Quality Care Team on Residents with signs and symptoms of depression.</p> <p>Social Services will report monthly to the Quality Assurance and Performance Improvement Committee and the Quality Assurance Coordinator will report quarterly to the Quality Assurance Committee with the Medical Director.</p>	

#CS/DDO/MEL
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F 250	Continued From page 8 depressed mood, because his score was not that high. *They confirmed if a resident did not score a ten on their mood assessment, it did not mean they could not benefit from some additional support. *The social worker confirmed he had voiced he had felt hopeless. He exhibited signs he was depressed and that should have been followed-up by them. -She had not done that. Review of the provider's 7/10/15 Social Service Mood policy revealed "Any resident with a mood score of moderate depression or above Social Services will visit with resident and/or family in regard to offering Mental Health Services. In addition Social Services will update the care plan to reflect needed approaches/interventions including other disciplines as necessary. Social Services will also visit these residents 1:1 as determined necessary based on the resident's mood/condition."	F 250			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281			

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F 281	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335</p> <p>Based on record review, interview, and policy review, the provider failed to ensure professional standards were followed regarding bowel management protocols for two of five sampled residents (1 and 14). Findings include:</p> <p>1. Interview on 4/11/16 at 4:15 p.m. with resident 1 revealed he was doing good except he had bowel issues the night before.</p> <p>Review of resident 1's medical record revealed he had: *No bowel movements on 2/29/16, 3/1/16, or 3/2/16. -Been given a suppository on 3/3/16 at 5:25 a.m. for constipation and had a large bowel movement. -Not been given milk of magnesia prior to the suppository. *No bowel movements on 3/4/16, 3/5/16, 3/6/16, or 3/7/16. -Been given a suppository on 3/8/16 at 5:37 a.m. for constipation. -Been given milk of magnesia on 3/8/16 at 3:44 p.m. to promote a bowel movement. *No bowel movements on 3/12/16, 3/13/16, 3/14/16, or 3/15/16. -Been given a suppository on 3/16/16 at 5:07 a.m. for constipation. -Not been given milk of magnesia prior to the suppository. *No bowel movements on 3/17/16, 3/18/16, 3/19/16, 3/20/16, or 3/21/16. -Been given milk of magnesia on 3/18/16 at 3:24 p.m. and on 3/22/16 at 12:38 a.m. to promote a bowel movement.</p>	F 281	<p>F281 (1)</p> <p>This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to residents #1 and #14. The Bowel Elimination: Bowel Control Program policy has been revised. The Director of Nursing will review this deficiency and the policy with all nurses and med aides at in-service training to be held on May 10, 2016 and May 11, 2016. The Director of Nursing or her designee will audit residents to ensure the policy is followed. Audits will be conducted on four residents weekly for 4 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p> <p><i>*CS/SPDOH/EL</i> <i>*has been followed correctly for all residents.</i> <i>CS/SPDOH/EL</i></p>	5-12-16

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F 281	<p>Continued From page 10</p> <p>-Been given a suppository on 3/22/16 at 5:23 a.m. for constipation and had a large bowel movement.</p> <p>*No bowel movements on 3/23/16, 3/24/16, and 3/25/16.</p> <p>-Been given milk of magnesia on 3/24/16 at 3:48 p.m. and on 3/25/16 at 4:00 p.m. to promote a bowel movement.</p> <p>-Been given a suppository on 3/26/16 at 5:21 a.m. for constipation and had an extra large bowel movement.</p> <p>*No bowel movements on 3/28/16, 3/29/16, and 3/30/16.</p> <p>-Been given milk of magnesia on 3/30/16 at 4:12 p.m. to promote a bowel movement.</p> <p>-Been given a suppository on 3/31/16 at 5:14 a.m. for constipation.</p> <p>*No bowel movements on 4/1/16, 4/2/16, 4/3/16, and 4/4/16.</p> <p>-Been given milk of magnesia on 4/2/16 at 4:03 p.m. and on 4/3/16 at 3:57 p.m. to promote a bowel movement.</p> <p>-Been given a suppository on 4/5/16 at 5:13 a.m. for constipation and had an extra large bowel movement.</p> <p>2. Review of resident 14's medical record revealed he had: *No bowel movements on 3/5/16, 3/6/16, or 3/7/16.</p> <p>-Been given milk of magnesia on 3/8/16 at 3:41 p.m. to promote a bowel movement.</p> <p>*No bowel movements on 3/23/16, 3/24/16, 3/25/16 or 3/26/16.</p> <p>-Been given milk of magnesia on 3/27/16 at 2:43 p.m. to promote a bowel movement.</p> <p>3. Interview on 4/13/16 at 2:00 p.m. with the director of nursing regarding residents 1 and 14</p>	F 281		

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

PRINTED: 04/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2016
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F 281	Continued From page 11 revealed the process used for bowel management included giving the resident prune juice if they had not had a bowel movement for one day. The prune juice was provided by the dietary department. If a resident had not had a bowel movement in two days they were to have been given a laxative. If a resident had not had a bowel movement for three days then a suppository would be given. They had not followed that protocol with resident 1 regarding the above situations. Interview on 4/13/16 at 4:00 p.m. with licensed practical nurse K revealed if a resident had not had a bowel movement in twenty-four hours they would be put on the prune juice list for the dietary department. If they had not had a bowel movement in forty-eight hours then they would be given a laxative. If they had not had a bowel movement in seventy-two hours then they would be given a suppository. Review of the provider's undated Bowel Elimination: Bowel Control Program policy revealed: *Certified nursing assistants were to document on the bowel movement log. *The medication nurse was responsible for checking the daily BM log. **"If a resident has not had a BM [bowel movement] for one day, give prune juice." **"If a resident has not had a BM for two days a laxative should be given." **"If a resident has not had a BM for 3 days, a suppository or enema is given."	F 281			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309			

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F 309	<p>Continued From page 12</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and contract review, the provider failed to ensure two of two sampled residents on hospice (11 and 13) had care plans integrated with hospice services. Findings include:</p> <p>1. Review of resident 11's medical record revealed: *She had been admitted on 2/14/11. *A physician's order had been obtained on 3/28/16 for hospice services.</p> <p>Review of resident 11's 4/5/16 care plan revealed: *"Problem: Resident and family have opted for hospice benefits and comfort care only." *Approaches included: -"Maintain open lines of communication and involvement with hospice staff." -"Keep family and hospice involved in care planning and decision making as well as updated on any changes in condition/orders." -"Monitor comfort/pain - offer meds [medication] as needed - repositioning - back rubs - keep skin clean and dry." -"Offer emotional and spiritual support to resident/family." -"Keep hospice staff involved with changes and</p>	F 309	<p>F309 (1,2,3)</p> <p>This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to residents #11 and #13. The Care Plan policy has been revised to include the integration of the services hospice provides. CNA daily sheets have been updated to indicate that a resident is on hospice. Care plans on those residents who are currently receiving hospice services have been updated. The Director of Nursing will provide education to the nursing staff at in-service training to be held on May 10, 2016 and May 11, 2016. The Director of Nursing or her designee will audit each care plan when a resident is opened to hospice services until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	5-12-16

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

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F 309	<p>Continued From page 13 notify them in event of death."</p> <p>Interview on 4/13/16 with registered nurse (RN) L revealed: *Hospice staff entered notes in the computerized medical record. *She would talk to hospice staff to discuss what they had done for the hospice resident that day. *She agreed the care plan had not specified what hospice would do.</p> <p>Interview on 4/13/16 with certified nursing assistant (CNA) M regarding resident 11 revealed she: *Did not know what services hospice provided for the resident. *Would refer to the CNA daily sheet to know what care to provide for the resident. *Agreed the CNA daily sheet did not mention the resident was receiving hospice services.</p> <p>Interview on 4/13/16 at 11:30 a.m. with RN G confirmed the care plan was not integrated with the hospice plan of care.</p> <p>Interview on 4/13/16 at 1:55 p.m. with the director of nursing (DON) confirmed the: *CNA daily sheets were updated daily, and it did not state resident 11 was receiving hospice services. *Care plan was not integrated with the hospice plan of care.</p> <p>Surveyor: 26180 2. Review of resident 13's entire medical record revealed:</p>	F 309			

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

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F 309	<p>Continued From page 14</p> <p>*She had been admitted on 3/23/16. *At the time of her admission her physician gave an order for hospice services.</p> <p>Review of resident 13's 3/23/16 care plan revealed: **Problem: Resident's family have opted for Hospice benefits and comfort care only. *Approaches included: -Maintain open lines of communication and involvement with Hospice staff. -Keep family and Hospice involved in care planning and decision making as well as update on any changes in condition/orders. -Monitor comfort/pain - offer meds [medications] as needed - repositioning -back rubs. -Offer emotional/spiritual support to resident and family. -Keep Hospice staff involved with changes and notify them in event of death." *None of the approaches specified what hospice was responsible for.</p> <p>Interview on 4/13/16 at 10:10 a.m. with licensed practical nurse F regarding resident 13 revealed: *She would talk to the charge nurse or the DON to find out what services hospice provided to the resident. *She agreed the care plan had not specified what hospice would do.</p> <p>Interview on 4/13/16 at 11:40 a.m. with the DON confirmed the care plan was not integrated with the hospice plan of care.</p> <p>3. Review of the Exhibit F Delineation of Nursing and Aide Services of the current hospice contract revealed: *The facility nurse was to coordinate "With</p>	F 309		

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

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F 309	Continued From page 15 Hospice staff in implementation and update of Joint Plan of Care." *The facility nursing assistants were to "Collaborate with Hospice Staff in implementation of Joint Plan of Care."	F 309		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on observation, interview, record review, and policy review, the provider failed to provide a secure environment to prevent one of one sampled residents (8) who was at risk for elopement from leaving the facility unnoticed. Findings include: 1. Observation on 4/12/16 at 12:15 p.m. of resident 8 revealed he was able to ambulate independently with the assistance of a walker. 2. Review of resident 8's complete medical record revealed he had a diagnosis of dementia. *Review of 8/3/15 fax showed the provider requested the removal of the Wanderguard alarm bracelet from resident 8 because the resident had not attempted an elopement. The physician	F 323		

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F 323	<p>Continued From page 16 approved the request on 8/4/15.</p> <p>*Review of the 2/21/16 Elopement Notice found he was last seen at 2:35 p.m. "in chapel/coffee social" which is held near the front door.</p> <p>*Review of the 2/21/16 Report of Resident Occurrence revealed: -The event occurred on a Sunday afternoon. -He had wandered out of the building at approximately 3:05 p.m. -An employee on her way home from work noticed a man she thought was a resident walking with his walker outside across the street. -The employee returned to the facility and alerted the nursing staff. -A search of the building was completed and resident 8 was not found. -The police were called and facility staff went out to search for the missing resident. -He was found by the staff at 3:42 p.m. on the 1600 block of 12th avenue SE. -He was dressed in a long sleeve shirt, pants, shoes, and socks, but had no coat on. -The temperature outside was 28 degrees Fahrenheit (F) with no wind. -His body temperature upon his return to the facility was 92.7 degrees F. -He had walked out the front door. That door was attended during the day hours Monday through Friday. The door was only alarmed and locked at night. -After the elopement the provider's plan was to alarm the door if they were unable to have the door watched.</p> <p>Review of Elopement Notices revealed: *Resident 8 had attempted elopement on 3/23/16 going out the G wing door at 2:15 a.m.</p>	F 323	<p>F323</p> <p>A (1,2) This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to resident #8. The Elopement policy and the Missing Person policy have been revisited. A new Wander management system that is also equipped with security features on all doors of the Nursing home facility is in the process of being installed. Completion is expected on or before May 6, 2016 at which time a new policy and procedure will be implemented. Six in-services will be held on May 10, 2016 and May 11, 2016 at which time the Administrator, Director of Nursing, and Staff Education Coordinator will review this deficiency and the policies for all staff.</p> <p>B (1,2,3,4,) This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to residents #6, #19, and #20. The Use of Call Light policy has been reviewed.</p>	5-12-16

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F 323	<p>Continued From page 17</p> <p>*Resident 8 had attempted elopement on 4/1/16 going out the Adult Day Center door at 8:15 p.m. *He had been brought back into the facility each time when the door alarm sounded.</p> <p>Interview on 4/13/16 at 3:15 p.m. with the director of nursing revealed she agreed the front door was not consistently attended during the day hours.</p> <p>Review of the provider's undated Elopement policy revealed: *Definition of elopement was when a resident left the facility building undetected without supervision of staff or a responsible party. **Policy: To allow a maximum amount of physical movement for all residents while minimizing the risk of resident elopement."</p> <p>Surveyor: 32335 B. Based on observation, interview, and policy review, the provider failed to answer call lights in a timely manner for three of three random residents (6, 19, and 20). Findings include:</p> <p>1. Observation on 4/12/16 from 7:55 a.m. through 8:18 a.m. of resident 19's room revealed the call light had been going off during that whole time. It had been turned off at 8:18 a.m. The call light was activated at the onset of the observation.</p> <p>2. Observation and interview on 4/13/16 at 8:05 a.m. with housekeeper R outside resident 20's room revealed: *The resident was yelling out for help, and his door was closed. *His call light had not been turned on. *Housekeeper R went into the room.</p>	F 323	<p>F323 (cont)</p> <p>Six in-services will be held on May 10, 2016 and May 11, 2016 at which time the Administrator, Director of Nursing, and Staff Education will review this deficiency and the policies. Education will include the prompt answering of call lights by all staff. The Director of Nursing or her designee will monitor the timely answering of call lights. Four call lights will be monitored weekly for four weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	

*CS/SD/DH/EL

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 18</p> <p>-There were no staff in the room, he asked the resident what he needed.</p> <p>-He then informed the resident he would put his call light on and left the room.</p> <p>*Care staff had not returned to the resident's room until 8:32 a.m.</p> <p>*Licensed practical nurse K had been at the nurses station during the above mentioned time frame but had not gone to answer the call light.</p> <p>Interview on 4/13/16 at 8:40 a.m. with certified nursing assistant S revealed resident 20 wanted to get up. She stated usually he did not get up until 9:00 a.m. They assisted other residents to get up prior to helping him. She had seen the call light on but was assisting another resident. She then went down the other hall to help another staff member.</p> <p>Surveyor: 33265</p> <p>3. Observation on 4/12/16 from 3:49 p.m. to 4:11 p.m. in the hallway outside of resident 6's room revealed:</p> <p>*His bathroom call light was already on at 3:49 p.m.</p> <p>*That call light remained on until 4:11 p.m. when it was answered by the infection control nurse.</p> <p>Interview on 4/12/16 at 4:12 p.m. with resident 6 revealed:</p> <p>*It was not uncommon for him to wait thirty minutes for a call light to be answered.</p> <p>*He waited longer during the day than during the night.</p> <p>*He believed it was because he was at the end of a hall.</p> <p>Surveyor: 32335</p> <p>4. Interview on 4/13/16 at 9:30 a.m. with the</p>	F 323			

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

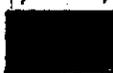
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F 323	Continued From page 19 director of nursing (DON) revealed the expectation was call lights would be answered within ten minutes. All staff could stop in to see what the resident needed including housekeeping staff and charge nurses. Interview on 4/13/16 at 2:10 p.m. with the DON and the education staff person revealed they had a committee for evaluating times of call lights. But had stopped it about one month ago. The educator and the DON were the ones responsible for conducting audits while the committee was meeting. They had not been doing audits in the past month. Review of the provider's 12/15/14 Use of Call Light policy revealed staff were to respond promptly to residents' call for assistance. All personnel should have been aware of call lights at all times. Staff should answer call lights promptly even if they were not assigned to that resident.	F 323			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 20 instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Routine temperature monitoring of one of two medication refrigerators (south station refrigerator). *Scheduled drugs waiting for destruction in two of two medication rooms (north and south) were secured from possible diversion. Findings include:</p> <p>1. Review of the south station medication refrigerator's temperature logs from 10/1/15 to 4/13/16 revealed the following numbers of dates were left blank: *In October, 2015, ten of thirty-one.</p>	F 431	<p>431 (1)</p> <p>This deficiency has the potential to affect all residents. Immediate education was given to ensure refrigerator temperature was being checked on refrigerators where medications are stored. The policy on Refrigeration Temperature Monitoring was reviewed. Six in-services will be held on May 10, 2016 and May 11, 2016 at which time the Administrator, Director of Nursing, and Staff Education will review this deficiency and the policies for all nurses. The Director of Nursing or her designee will audit all refrigerators where medications are stored weekly for 4 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	5-12-16

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F 431	<p>Continued From page 21</p> <ul style="list-style-type: none"> *In November, 2015, eleven of thirty. *In December, 2015, twelve of thirty-one. *In January, 2016, thirteen of thirty-one. *In February, 2016, two of twenty-nine. *In March, 2016, nine of thirty-one. *In April, 2016, five of thirteen. <p>Interview on 4/13/16 at 3:15 p.m. with the director of nursing revealed she agreed there had not been routine monitoring of the temperature in the south station medication refrigerator.</p> <p>Review of the provider's July 2005 Refrigerator Temperature Monitoring form revealed:</p> <ul style="list-style-type: none"> *Refrigerators where medications were stored were to be monitored daily by the nursing staff with the temperature recorded on the log sheet. *Those refrigerators were to be kept between 36 and 46 degrees F. *If the refrigerator temperature was found to be outside of that range the temperature was to be adjusted by the nurse, and maintenance was to be notified. <p>2. Observation and interview on 4/13/16 at 11:00 a.m. of the north side medication room with licensed practical nurse (LPN) F revealed:</p> <ul style="list-style-type: none"> *Scheduled medications were stored until destruction in a locked cupboard. *A log sheet of each separate medication was kept in a notebook on the counter. *Medications to be destroyed were stored in the same manner in both the north and south station medication rooms. <p>Interview on 4/13/16 at 3:15 p.m. with the director of nursing revealed she:</p> <ul style="list-style-type: none"> *Agreed with the above description of how medications were being stored before being 	F 431	<p>F 431 (2)</p> <p>This deficiency has the potential to affect all residents. The Policy for Destruction of Discontinued Medication has been reviewed and revised by the Director of Nurses and Pharmacist. Discontinued narcotics will be placed in a locked narcotic box of which only the Director of Nursing and Pharmacist have a key. This deficiency and the policy will be reviewed by the Director of Nursing to all nurses at in-service training to be held on May 10, 2016 and May 11, 2016. The Director of Nursing or her designee will audit that discontinued narcotics are placed in locked narcotic box until destroyed. Audits will continue until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	<p>*05/02/2016</p> 

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CENTERS FOR MEDICARE & MEDICAID SERVICES

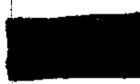
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/13/2016
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401		
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F 431	Continued From page 22 destroyed. *Agreed if a nurse removed the medication container and removed that medication's log sheet from the notebook there would be no way of knowing the medication had been taken. Review of the provider's undated Medications Discontinued policy revealed if the medication was a controlled substance the medication was to have been locked in the narcotic cupboard until it was destroyed.	F 431			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441			

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F 441	<p>Continued From page 23</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 A. Based on observation, interview, procedure review, policy review, manufacturer's instructions review, and product label instructions, the provider failed to ensure appropriate infection control measures were in place for: *The cleaning of the finger used for the blood sugar testing for one of three randomly observed blood sugar tests by one of three randomly observed staff (registered nurse [RN] H). *The disinfection of glucometers (measures blood sugar) for one of three randomly observed (resident 21) blood sugar test by one of three randomly observed staff (RN H). *The disinfection of therapy equipment in one of one therapy rooms after each use by multiple residents.</p>	F 441	<p>441</p> <p>A. (1&2) This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to residents #21. The policies and procedures for Maintaining Assure Platinum Meter, Quality Control Testing on Assure Platinum Meter and Performing a Blood Glucose Test with Assure Platinum Meters has been reviewed and revised. The Staff Education Coordinator will review this deficiency and the policy with all nurses *including at in-service training to be held on May 10, 2016 and May 11, 2016. Four residents will be monitored during glucose testing weekly for 4 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p> <p style="text-align: right;">CS/SDD/DEL</p>	5-12-16

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

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F 441	<p>Continued From page 24</p> <p>Findings include:</p> <p>1. Observation and interview on 4/12/16 at 11:34 a.m. of RN H with resident 21 revealed RN H cleaned the finger of resident 21. RN H used a water dampened gauze prior to the finger stick for testing of the blood glucose level. She stated that was her usual process for cleaning the area to be punctured.</p> <p>Interview, procedure review, and glucometer's manufacturer's instruction review on 4/13/16 at 2:35 p.m. with the infection control nurse revealed:</p> <p>*Their policy was to use a piece of gauze dampened with water to cleanse the finger stick area that was to be punctured.</p> <p>*The manufacturer's instructions stated to wash hands with soap and water or use alcohol wipes and allow the area to dry before puncturing.</p> <p>*The infection control nurse agreed they were not following the manufacturer's instructions.</p> <p>Interview, procedure review, and glucometer's manufacturer's instruction review on 4/12/16 at 3:15 p.m. with the director of nursing revealed she agreed they were not following the manufacturer's instructions.</p> <p>Review of provider's 1/2/14 Performing a Blood Glucose Test with Assure Platinum Meter procedure revealed they were to cleanse the area that was to be punctured with gauze and warm water, then dry the area with gauze.</p> <p>Review of the undated glucometer's manufacturer's instructions revealed there were two options for cleaning the finger before puncturing it. Those were:</p>	F 441	<p>F441</p> <p>A. (3) This deficiency has the potential to affect all residents. A policy and procedure for disinfecting of therapy equipment has been completed. Education to all therapy staff was given on April 14, 2016. Six in-services will be held on May 10, 2016 and May 11, 2016 at which time the Director of Nursing will review this deficiency and the policies for all staff. The Restorative Nursing Coordinator will audit the disinfecting of therapy equipment between use, 3 times daily for 1 week, then weekly for one month and monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Restorative Nursing Coordinator will report monthly to the Quality Assurance and Performance Improvement Committee and the Quality Improvement Coordinator will report quarterly to the Quality Assurance Committee with the Medical Director.</p>	<p>*OS/SDOJ/EL</p> 

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F 441	<p>Continued From page 25</p> <p>*Wash hands with soap and warm water then dry hands thoroughly. *Use an alcohol swab and allow the alcohol to dry.</p> <p>2. Observation and interview on 4/12/16 at 11:34 a.m. of RN H in resident 21's room revealed: *She used a Super Sani-Cloth wipe to clean the outside of the glucometer after doing a blood sugar reading. *She wiped down the glucometer with the cloth for ten seconds, and then immediately placed the glucometer back in the container. *She stated that was her usual process for cleaning the glucometer.</p> <p>Interview, procedure review, Super Sani-Cloth manufacturer's instruction review, and Super Sani-Cloth product label instructions review on 4/13/16 at 2:35 p.m. with the infection control nurse revealed: *Their policy was to follow the product label instructions to clean and disinfect the glucometer. *The manufacturer's instructions on cleaning the glucometer stated to clean and disinfect by using a commercially available EPA (environmental protection agency) registered disinfectant or germicidal wipe. *The manufacturer's instructions on the label of the germicidal wipe stated to allow the treated surface to remain wet with the solution for two minutes, and then allow it to air dry. *The infection control nurse agreed they were not following the manufacturer's instructions or product label instructions.</p> <p>Interview, procedure review, Super Sani-Cloth manufacturer's instructions review, and Super Sani-Cloth product label instructions review on</p>	F 441	<p>F441</p> <p>B. (1) This deficiency has the potential to affect all residents. The Director of Nursing has determined there were no negative outcomes to resident #7. The policy on Hand Cleansing has been reviewed. Six in-services will be held on May 10, 2016 and May 11, 2016 at which time the Administrator, Director of Nursing, Staff Education Coordinator will review this deficiency and the policies for all staff. The Director of Nursing or her designee will monitor staff for proper hand hygiene. Four staff members will be monitored weekly for four weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Director of Nursing will report monthly to the Quality Assurance and Performance Improvement Committee and quarterly to the Quality Assurance Committee with the Medical Director.</p>	

*including CNA E: CS SDDOH/EL

*CS/SDDOH/EL

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	<p>Continued From page 26 4/12/16 at 3:15 p.m. with the director of nursing revealed she agreed they were not following the manufacturer's and product label's instructions.</p> <p>Review of provider's 1/2/13 Maintaining the Assure Platinum Meter procedure revealed they were to follow the product label instructions to disinfect the glucometer.</p> <p>Review of the undated Glucometer Manufacturer's instructions revealed they were to clean and disinfect the glucometer using a commercially available EPA (environmental protection agency) registered disinfectant or germicidal wipe.</p> <p>Review of the undated Super Sani-Cloth product label instructions revealed the object being disinfected was to remain wet with the solution for two minutes. Then allow the object to air dry.</p> <p>Surveyor: 35121 3. Observation on 4/12/16 at 2:00 p.m. of the therapy room revealed several residents using exercise equipment.</p> <p>Interview on 4/12/16 at 2:08 p.m. with therapy assistant N and aquatics instructor O revealed they cleaned therapy equipment at the end of each day.</p> <p>Interview on 4/12/16 at 2:18 p.m. with the restorative nursing coordinator Q confirmed they: *Did not clean therapy equipment after each resident's use. *Cleaned therapy equipment at the end of each day.</p> <p>Interview on 4/12/16 at 2:45 p.m. with interim</p>	F 441		

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

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F 441	<p>Continued From page 27</p> <p>maintenance supervisor P confirmed she agreed therapy equipment should have been cleaned after each resident's use.</p> <p>Interview on 4/13/16 at 11:04 a.m. with the infection control nurse confirmed she would have expected the therapy equipment to be cleaned after each resident's use.</p> <p>Interview on 4/13/16 at 3:08 p.m. with the DON confirmed: *She agreed equipment used by more than one resident should have been cleaned after each resident's use. *She would have expected therapy equipment to have been needed to be cleaned in the same timeliness as resident lifts (machine that assists in lifting a resident). *The facility did not have a therapy equipment cleaning policy.</p> <p>Review of the provider's undated Transfers: Hoyer Mechanical Lift policy revealed "Hoyer lift should be disinfected between resident use."</p> <p>Surveyor: 26180 B. Based on observation, interview, and policy review, the provider failed to ensure proper hand hygiene was used for one of seven sampled residents (7) during personal cares. Findings include:</p> <p>1. Observation on 4/12/16 at 8:00 a.m. of certified nursing assistant (CNA) E revealed she entered resident 7's room and provided care to get the resident up for the day. CNA E: *With gloved hands and moistened dry wipes washed the resident's perineal area.</p>	F 441		

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

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F 441	<p>Continued From page 28</p> <p>*Stated "You have had a small bowel movement so I am going to wash you up."</p> <p>*After washing her bottom she removed her gloves and put them in the soiled incontinent pad, rolled them up and placed them in a garbage bag.</p> <p>*Without washing her hands or performing any hand hygiene she:</p> <ul style="list-style-type: none"> -Continued to place the Hoyer lift sling under the resident. -Used her walkie-talkie to call for assistance. -Got the resident up using the Hoyer lift. <p>*Upon completion of getting the resident out of bed and positioned in her wheelchair she then washed her hands.</p> <p>*When she completed washing her hands she shut the water faucet off using her bare hands.</p> <p>Interview on 4/13/16 at 11:40 a.m. with the DON revealed:</p> <ul style="list-style-type: none"> *Staff should always have performed hand hygiene after providing toileting care. *CNA E should have shut the water off using a paper towel not her bare hands. <p>Review of the provider's undated hand cleansing policy revealed:</p> <ul style="list-style-type: none"> *"Hand hygiene continues to be the primary means of preventing the transmission of infection. The following is a list of some situations that require hand hygiene: -When hands are visibly soiled (hand washing with soap and water). -Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice). -Before and after assisting a resident with toileting (hand washing with soap and water)." *The hand cleansing procedure read "Use clean disposable hand towel to turn off faucet and to 	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 29 open door if exiting a room."	F 441			

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

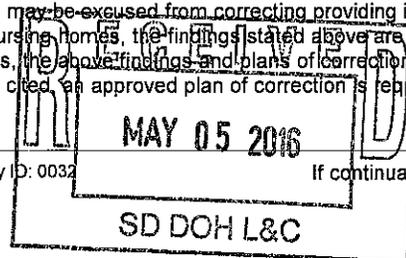
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K 000	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/13/16. Bethesda Home of Aberdeen (building 01-original structure) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029, K052, K066, and K147 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 029 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure separation of hazardous rooms was provided in one randomly observed area (laundry room). Findings include: 1. Observation at 12:45 p.m. on 4/13/16 revealed a laundry room door that was held open with a magnetic hold-open device tied to the building fire	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Bruce A. Johnson* TITLE *Administrator* (X6) DATE *May 4, 2016*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 029	Continued From page 1 alarm system. Testing of the door by releasing it from the magnetic hold-open revealed the door would close into the door frame. The positive latching hardware did not engage when the door closed. The latching hardware would stick in the door and not allow the hardware to latch into the door frame. Interview with the compliance officer at the time of the above observation confirmed that condition. She indicated all doors to hazardous rooms were on a preventative maintenance schedule and were working fine when last checked within the last month. This deficiency has the potential to affect one of ten smoke compartments.	K 029	K029 (1) This deficiency has the potential to affect all laundry personnel. The door closure on the laundry room door was adjusted to latch properly on April 13, 2016. The Maintenance Director or his designee will audit that all self-closing doors are in proper working condition. Audits will be done weekly for four week then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Maintenance Director will report monthly to the Quality Assurance and Performance Improvement Committee.		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the building fire alarm initiation system was maintained in accordance with NFPA 72 National Fire Alarm and Signaling Code in one randomly observed location. The main entrance manual pull station was not readily visible. Findings include: 1. Observation at 10:00 a.m. on 4/13/16 revealed	K 052		5-12-16	

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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	
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K 052	Continued From page 2 a fire alarm manual pull station adjacent to the main entrance sliding doors. The manual pull station was being blocked by an informational sign and was not readily visible to building occupants for use in an emergency situation. Interview with the administrator during the exit interview at 3:45 p.m. on 4/13/16 revealed he was unaware of that condition. This deficiency has the potential to affect one of ten smoke compartments.	K 052	K052 (1) This deficiency has the potential to affect all residents. The information sign was removed from in front of the fire alarm pull station on April 13, 2016. All staff will be educated on the importance of pull stations being readily visible. Education will be done at in-services to be held on May 10, 2016 and May 11, 2016. The Maintenance Director or his designee will audit all Fire Alarm Pull Stations monthly for 4 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Maintenance Director will report monthly to the Quality Assurance and Performance Improvement Committee.	
K 066 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 32334	K 066		5-12-16

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2016
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 066	Continued From page 3 Based on observation and interview, the provider failed to ensure smoking regulations conformed to life safety codes standards in two randomly observed locations. Ashtrays were not provided with a lid at the main entrance and the G wing entrance. Findings include: 1. Observation at 10:00 a.m. on 4/13/16 revealed a cigarette disposal can near the front entrance that was a combination ashtray and trash can. The ashtray on top of the can did not have a self-closing lid or cover. A proper metal disposal can with a lid was also provided in that area. It was witnessed that cigarettes were still being disposed in the un-lidded can. This condition was also observed in the G wing entrance. Interview with the administrator during the exit interview at 3:45 p.m. on 4/13/16 revealed he was unaware of the covered ashtray requirement. This deficiency has the potential to affect two of ten smoke compartments.	K 066	K066 (1) This deficiency has the potential to affect all residents. The combination ashtray/trash cans were removed from the front entrance and the G wing entrance on May 3, 2016. Smoking Genies and separate trash receptacles were placed both entrances. The Maintenance Director or his designee will audit all entrances for proper receptacles monthly for 4 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Maintenance Director will report monthly to the Quality Assurance and Performance Improvement Committee.		
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure the electrical system was maintained in accordance with NFPA 70 National Electric Code in three randomly observed locations. The electrical panels in the G, E, and D wings were not provided with proper circuit panel directories. Findings include:	K 147			
			5-12-16		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2016
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 147	<p>Continued From page 4</p> <p>1. Observation at 2:35 p.m. on 4/13/16 revealed an electrical panel in the G wing air handling room. A piece of paper was taped to the panel indicating the circuit directory. That piece of paper had the potential to be misplaced. The designated circuit panel directory located on the panel door should have been updated to reflect the circuit names.</p> <p>Interview with the compliance coordinator at the time of the above observation confirmed that condition. She indicated those panels were new when the generator was installed in 2015 and must not have been updated yet.</p> <p>This deficiency has the potential to affect four of ten smoke compartments.</p>	K 147	<p>K147 (1)</p> <p>This deficiency has the potential to affect all maintenance personnel and outside contractors. The electrical panels in G, E, and D were properly labeled by the Corporate Compliance Officer on April 29, 2016.</p>	4-29-16	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2016
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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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/13/16. Bethesda Home of Aberdeen (Building 02 addition) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bruce A. Johnson, Administrator</i>	TITLE Administrator	(X6) DATE May 4, 2016
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - ADULT DAYCARE B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2016
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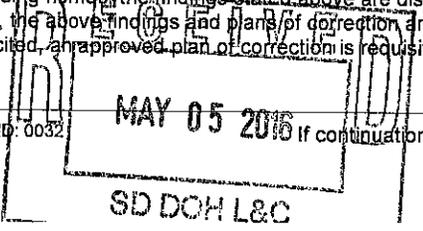
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN	STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32334 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 4/13/16. Bethesda Home of Aberdeen (Building 03-therapy addition) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for new health care occupancies upon correction of deficiency identified at K038 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 038 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the facility failed to ensure exits were readily available at all times in one of six exits from the day care center. Findings include:</p> <p>1. Observation at 2:30 p.m. on 4/13/16 revealed an exit door at the south east corner of the building. That exit door was equipped with a delayed egress locking feature that would alarm when the panic bar was pushed and unlock after fifteen seconds. That door was not provided with the proper signage indicating the means to unlock that door. That door should have been provided with code required signage indicating "push until alarm sounds door can be opened in 15 seconds."</p>	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **may 4, 2016**

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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K 038	<p>Continued From page 1</p> <p>Interview with the compliance officer at the time of the above observation confirmed that condition. She indicated she was aware the sign should have been installed on the door. She was unsure why that door was not provided with that signage.</p> <p>This deficiency has the potential to affect one of two smoke compartments.</p>	K 038	<p>K038 (1)</p> <p>This deficiency has the potential to affect all residents. A temporary sign to indicate the means to unlock the door was placed on the exit door on May 3, 2016. A permanent sign has been ordered that will read "Push until alarm sounds. Door can be opened in 15 seconds." The Maintenance Director will report monthly to the Quality Assurance and Performance Committee until the permanent sign is installed.</p>	5-12-16

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/13/2016
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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
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/11/16 through 4/13/16. Bethesda Home of Aberdeen was found not in compliance with the following requirement: S169.	S 000		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35121 Based on observation and interview, the provider failed to ensure three of seven exit doors (main entrance, and doors marked as G and H on an alarm panel) were alarmed or properly monitored. Findings include: 1. Observation on 4/12/16 at 7:10 a.m. revealed	S 169		

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

TITLE

(X6) DATE

Bruce A. Johnson

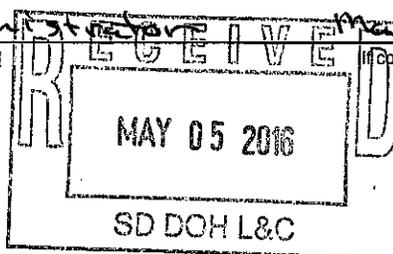
Administrator

May 4, 2016

STATE FORM

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If continuation sheet 1 of 3

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2016
NAME OF PROVIDER OR SUPPLIER BETHESDA HOME OF ABERDEEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1224 S HIGH ST ABERDEEN, SD 57401		
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S 169	<p>Continued From page 1</p> <p>the main entrance door alarm was not audible at the time of the observation. The main entrance door was within sight distance of the front desk staff when staff were present.</p> <p>The main entrance door was observed not alarmed or monitored on: *4/12/16 at 7:10 a.m. *4/12/16 at 12:45 p.m. *4/12/16 at 5:30 p.m. *4/13/16 at 7:15 a.m. while resident 22 was sitting in his wheelchair near the main entrance door.</p> <p>Interview on 4/13/16 at 10:15 a.m. and at 11:45 a.m. with the administrator regarding the main entrance door confirmed: *There was an alarm in place that had been turned off during the day. *The alarm was on a timer to be activated from 7:00 p.m. until 7:00 a.m. *Front desk staff were scheduled for Monday through Friday from 8:00 a.m. until 5:00 p.m. *There were no front desk staff scheduled for weekends. *There were times during the day when the front door alarm was off, and it was not monitored by staff. *A resident had left through that door without staff knowledge in February 2016. *Nothing new had been implemented to deter elopements through the main entrance. *A new door alarm system had been ordered on 3/16/16.</p> <p>Observation on 4/13/16 at 4:20 p.m. of exit doors G and H revealed their alarms were not activated.</p> <p>Interview on 4/13/16 at 4:25 p.m. with licensed practical nurse K regarding exit doors G and H revealed he:</p>	S 169	<p>S169 (1)</p> <p>This deficiency has the potential to affect all residents. All doors were locked immediately on April 13, 2016. All doors have remained locked except the front door which is unlocked between 6am and 8pm. A staff member has been stationed at the front door to monitor the door whenever it has been unlocked. A contract was signed on February 24, 2016 with United Technologies to install a new Wander management system that is also equipped with security features on all doors of the Nursing home facility. Installation is expected to be completed May 6, 2016. Education regarding the system will be presented to all staff in-services to be held on May 10, 2016 and May 11, 2016. The Maintenance Director or his designee will audit al the Wander management system monthly for 4 weeks and then monthly until the Quality Assurance and Performance Improvement Committee decides to discontinue. The Maintenance Director will report monthly to the Quality Assurance and Performance Improvement Committee.</p>	5-12-16

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/13/2016
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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
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S 169	<p>Continued From page 2</p> <p>*Agreed the alarm was not on for those doors. *Did not know how to turn the alarm on.</p> <p>Interview on 4/13/16 at 4:34 p.m. with the administrator regarding exit doors G and H confirmed: *They were equipped with audible alarms. *The alarms were not on. *He had been aware those alarms were off during the day.</p> <p>A door alarm policy was requested, but the facility did not have one.</p>	S 169		
S 000	<p>Compliance/Noncompliance Statement</p> <p>Surveyor: 26180 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 4/11/16 through 4/13/16. Bethesda Home of Aberdeen was found in compliance.</p>	S 000		