

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

PRINTED: 06/28/2016
FORM APPROVED
OMB NO. 0938-0391

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 C 06/09/2016
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 000	INITIAL COMMENTS Surveyor: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/7/16 through 6/9/16. Bethany Home - Brandon was found not in compliance with the following requirements: F246, F279, F323, F371, 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 6/7/16 through 6/9/16. Areas surveyed included quality of care, treatment. Bethany Home - Brandon was found not in compliance with the following requirements: F157 and F279.	F 000	* Addendums noted with an asterisk per 7/11/16 per telephone with facility administrator. JVE/SPDOH/EL		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157		7/29/16	

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

TITLE

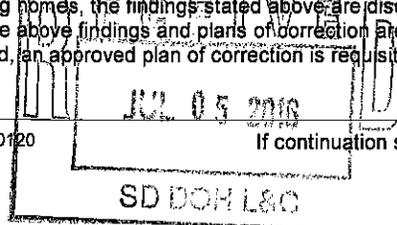
(X6) DATE

Jane Gunnickson

Administrator

7/11/16

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



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F 157	<p>Continued From page 1</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure one of two sampled discharged resident's (14) family had received timely notification of a change in condition (fall). Findings include:</p> <p>1. Review of resident 14's medical record revealed: *She was admitted on 7/31/15. *Her 8/6/15 admission Minimum Data Set assessment revealed: -She had a Brief Interview for Mental Status (test to measure ability to think and remember) score of seven out of fifteen indicating severe cognitive impairment. *She had two unwitnessed falls. -The first fall occurred on 8/1/15 at 11:00 p.m. while she was attempting to self-transfer in her bathroom. -The second fall occurred on 8/2/15 at 7:10 p.m. while she was attempting to self-transfer in her room.</p>	F 157			

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F 157	<p>Continued From page 2</p> <p>Review of resident 14's nurses progress note on 8/2/15 at 11:55 p.m. by licensed practical nurse (LPN) M revealed: *She had fallen on 8/2/15 at 7:10 p.m. *Her daughter and durable power of attorney (legal representative for healthcare) had been called on 8/2/15 at 8:30 p.m. to inform her regarding the above fall. -At the same time the daughter was informed of a fall that had occurred earlier. -The "daughter stated that the nurse on the prior shift had never contacted her about the first fall." -She stated she preferred to be informed of falls as soon as possible.</p> <p>Review of resident 14's interdisciplinary note on 8/3/15 at 12:30 p.m. by the social service director confirmed her daughter requested to be notified of any falls regarding her mother as soon as possible.</p> <p>Interview on 6/9/16 at 1:20 p.m. with the director of nursing regarding resident 14 revealed: *She expected family to be notified of a fall immediately after the physician was notified. *Notification of a fall to the family was to have been done within an hour as much as possible. *Family notification would be delayed only if the family preferred not to be called in the middle of the night. -Then the call would have been placed at the end of the night nurse's shift in the early morning. *She acknowledged the family should have been notified earlier regarding her fall on 8/1/15 at 11:00 p.m. *She confirmed the family had not been notified of the first fall until 8/2/15 at 8:30 p.m. *She agreed the family had not been notified of</p>	F 157	<p>F 157</p> <p>"Resident Change in Condition" protocol reviewed by DON on 6/29/2016 and updated to reflect a clear timeline for notifying family and POA when fall or other significant change occurs. "Accidents and Supervision, Fall Risk Management, and Fall Prevention" policy reviewed by DON on 6/29/2016 and found to be accurate. Nursing staff educated by DON on 6/29/2016 about this policy and the importance of notifying families of change in condition, including falls, within 24 hours. Beginning 7/29/2016 the Safety Committee (comprising DON, nurse managers and Social Services) will audit documentation on falls weekly to ensure notification of POA and physician occurred within 24 hours. Social Services will report results of this audit to the quarterly QAPI committee as long as the committee determines necessary.</p>		

*all JVE/SJ/DH/EL

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F 157	Continued From page 3 the first fall on 8/1/15 at 11:00 p.m. in a timely manner. Review of the provider's 12/2/13 Resident Change in Condition protocol revealed: *"Assure responsibility party notification and confirmation of notification is documented within the shift or sooner based on urgency of the condition." *A change in condition had included falls.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Surveyor: 29354	F 246		7/29/16

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F 246	<p>Continued From page 4 Surveyor: 32331</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure 1 of 13 sampled residents (5) was appropriately positioned at the table during meals. Findings include:</p> <p>1. Observation and interview on 6/7/16 of resident 5 during the evening meal in Cottonwood Court revealed: *He used a motorized wheel chair and sat in it to eat. *Two other residents sat at the table in regular chairs. *His wheelchair was too high for the table. *He had to bend over to reach his food. *He admitted he was uncomfortable, and it was hard to eat.</p> <p>Review of resident 5's medical record revealed he: *Had a diagnosis of left hemiplegia (left sided weakness) from a stroke and had difficulty using his left hand. He could use his right hand. *Was unable to walk and needed extensive assistance of two staff to transfer from one place to another. *Used a motorized wheel chair. *Had a Brief Interview for Mental Status assessment (mental thinking assessment) on 5/24/16 with a score of fifteen showing he was able to think for himself. *Was able to feed himself.</p> <p>Surveyor: 32331 Interview on 6/8/16 at 7:35 a.m. in the Cottonwood Court dining room with resident 5 revealed he:</p>	F 246	<p>F 246</p> <p>"Resident Dignity" policy reviewed by DON and Admin. on 6/26/2016 and found to be accurate. Resident 5 assessed by DON on 6/9/2016 and was immediately seated at a raised table with other appropriately seated residents. PTA completed follow up assessment on 6/29/2016 verifying that seating at raised table was appropriate for resident's needs. Care plan updated by DON on 6/29/2016 to reflect resident preference of raised table as appropriate seating for resident while dining. DON or designee will evaluate all current residents seating by 7/29/2016 to ensure appropriate seating at meals, and make adjustments as needed. DON or designee will evaluate each dining room once weekly to ensure that all residents are appropriately seated during meals. DON or her designee will report results to quarterly QAPI committee meeting as long as the committee determines necessary. All nursing staff educated on the "Resident Dignity" policy regarding appropriate seating at meals on 6/29/2016.</p>	

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F 246	Continued From page 5 *Was seated in his motorized wheelchair (w/c) at his dining room table for breakfast. *Complained the dining room table was a "little low" for him. -Had some pain from bending down toward the table to eat. -Had been unable to get comfortable and relaxed in his w/c to eat his meal. Surveyor: 34030 Interview on 6/8/16 at 9:50 a.m. with certified occupational therapist assistant M regarding the above revealed: *She had not been made aware of resident 5's difficulty with reaching the table during meals, so it had not been addressed. **"That would explain why he was spilling food." Interview on 6/8/16 at 9:55 a.m. with the director of nursing regarding positioning of resident 5 at meals revealed she had been unaware there had been a problem. Review of the provider's undated Resident Dignity policy revealed "Promoting independence and dignity in dining."	F 246			
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		7/29/16	

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F 279	<p>Continued From page 6 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, observation, and policy review, the provider failed to accurately revise the care plans for: *One of two sampled discharged residents (14) who had a personal preference for caregivers. *One of thirteen sampled residents (4) who no longer was able to self-administer her own medications. *One of two sampled residents (8) who triggered for pain. *One of one sampled resident (1) who had a pressure ulcer. *Two of two sampled residents (3 and 7) on psychotropic (mood altering) medications. *Two of two sampled residents (7 and 9) in the memory care unit. *One of one sampled resident (6) with a half-lap tray. Findings include:</p> <p>1. Review of resident 14's medical record revealed: *She was admitted on 7/31/15.</p>	F 279			

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F 279	<p>Continued From page 7</p> <p>*Her 8/6/15 admission Minimum Data Set (MDS) assessment revealed: -She had a Brief Interview for Mental Status (test to measure ability to think and remember) score of seven out of fifteen indicating severe cognitive impairment. -She needed extensive assistance of one with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing.</p> <p>Review of the 7/31/15 nurses notes by licensed practical nurse (LPN) O regarding resident 14 revealed: *She "needs assistance of 1 with all cares, cueing with eating, and oral cares." **"Daughter expressed that resident is not comfortable with help from male staff for bathing, toileting, and dressing."</p> <p>Review of resident 14's 8/3/15 care plan revealed: *She had a cognitive (thinking) impairment *There was no documentation regarding her preference for caregivers.</p> <p>Interview on 6/9/16 at 1:30 p.m. with the director of nursing (DON) LPN F regarding resident 14's preference for caregivers revealed: *The DON stated the facility had male caregivers on staff during the time of her stay at the facility. *LPN F stated a female resident's preference for no male caregivers would have been communicated in a verbal report at shift change. *The DON stated the nursing staff would have been responsible for updating the care plan regarding the resident's preference for caregivers. *Both agreed the above needed to have been on the care plan for staff to have been aware of the</p>	F 279		

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F 279	<p>Continued From page 8 resident's preference for caregivers.</p> <p>Review of the provider's undated Resident Dignity policy revealed: *Staff promoted care for residents in a manner that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. *It included: -Providing treatment and care of resident's personal needs with respect to his or her dignity. -Assisting residents with choosing health care consistent with their plan of care. -Maintaining resident privacy of body.</p> <p>Review of the provider's undated Long Term Care Facilities Resident's Bill of Rights revealed: *There was a choice in care planning. *The right to privacy and confidentiality had included personal care.</p> <p>2. Review of resident 4's medical record revealed she had: *Been admitted on 6/24/13. *Diagnoses that had included chronic pain, anxiety disorder, and mood disorder with depressive (sad) features.</p> <p>Review of the 4/18/16 physician's order for resident 4 revealed: **"It is not safe for the resident to self-administer the listed medications." *Those listed medications were: -Tucks (for relief from hemorrhoids). -Biofreeze (pain reliever). -Tums (for relief of heartburn and indigestion). -Proctozone-HC 2.5 percent cream (for relief from hemorrhoids).</p>	F 279	<p>The "Resident Dignity" policy was reviewed 6/28/2016 by DON and found to be accurate.</p> <p>Resident 14 discharged 8/14/2015 so specific changes were not made to resident care plan. LPN O is also no longer employed with Bethany so no personal inservicing occurred.</p> <p>Resident 4's care plan updated by RN E on 6/17/2016 to reflect the doctor's order that resident cannot self-administer medications.</p>	

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F 279	<p>Continued From page 9</p> <p>Review of the revised 4/12/16 care plan for resident 4 revealed:</p> <ul style="list-style-type: none"> *She had a focus area for arthritis. *Under interventions/tasks for the above area: <ul style="list-style-type: none"> - "May use specific medications at bedside for self-administration per doctor order." *She had a focus area for "[Resident's name] can self administer medications at dining room table." *Under the goal for the above area: <ul style="list-style-type: none"> - "[Resident's name] will safely self administer medications at the dining room table with nursing observation through the review date." *Under the interventions/tasks for the above area: <ul style="list-style-type: none"> - "[Resident's name] may use specific medications at bedside for self administration per doctor order." *The care plan had not been updated with current physician's orders for no self-administration of medications. <p>Interview on 6/8/16 at 1:50 p.m. with the DON regarding resident 4 revealed:</p> <ul style="list-style-type: none"> *She was no longer able to self-administer medications. *She stated the care plan had not been updated. *The DON stated the nursing staff would have been responsible for updating the care plan regarding the discontinuance of self-administration. <p>Surveyor: 35121</p> <p>3. Review of resident 8's medical record revealed:</p> <ul style="list-style-type: none"> *She had diagnoses of pain, rheumatoid arthritis, and osteoarthritis. *She had physician's orders for: <ul style="list-style-type: none"> - Tylenol (pain medication) three times a day and as needed. - Ibuprofen (pain medication) as needed. 	F 279			

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F 279	<p>Continued From page 10</p> <p>*Her care plan instructed to ask resident if she had pain "BID [twice daily] and offer PRN [as needed] ibuprofen.</p> <p>*No other interventions for pain were documented on her care plan.</p> <p>4. Review of resident 1's medical record revealed: *A new pressure ulcer was found on her coccyx (tailbone) on 12/3/15. *The pressure ulcer was a stage II (partial thickness skin loss). *She had a physician's order for Venelex (medicated ointment) to the area twice daily. *Her care plan instructed to offer her two eggs at breakfast and increased portions of meat at lunch and dinner for increased protein. *No other interventions for treating or preventing pressure ulcers were documented on her care plan.</p> <p>5. Interview on 6/8/16 at 11:40 a.m. with RN E revealed: *He was responsible for updating the care plans. *Resident 8's care plan should have included interventions for pain other than offering pain medications. *Resident 1's care plan should have included interventions for treating and preventing pressure ulcers. *None of the above listed interventions were on their current care plans.</p> <p>Surveyor: 29354</p> <p>6. Review of resident 3's medical record revealed: *She had diagnoses of Alzheimer's disease, anxiety, and depression.</p>	F 279	<p>Resident 8's care plan reviewed and revised 6/8/2016 by RN E to include non-pharmalogical interventions for pain.</p> <p>Resident 1's care plan reviewed and revised on 6/8/2016 by RN E. Revisions include alternate interventions for treating or preventing pressure ulcers.</p> <p>"Plan of Care" policy reviewed by DON on 6/28/2016 and updated to include the following "Care plan will be updated by a nurse on an ongoing basis, and reviewed and updated as</p>		

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F 279	<p>Continued From page 11</p> <p>*She had physician's orders for clonazepam (antianxiety) and Ativan (antianxiety) prn (when needed) medications.</p> <p>*There was no documentation on the current care plan she was receiving antianxiety medications.</p> <p>7. Review of resident 7's medical record revealed: *He had diagnoses of dementia and anxiety disorder. *He had a physician's order to reside on the locked memory care unit (Maple Valley). *He had physician's orders for Quitiapine Fumarate (antipsychotic) and Sertraline (antidepressant) medications. *There was no documentation on the current care plan he resided on the memory care unit and had been receiving antipsychotic and antidepressant medications.</p> <p>8. Review of resident 9's medical record revealed: *She had diagnoses of dementia, anxiety, and depression. *She had physician's orders to reside on the locked memory care unit (Maple Valley). *There was no documentation on the current care plan she resided on the memory care unit.</p> <p>9. Interview on 6/8/16 at 8:42 a.m. with registered nurse E regarding resident's 3, 7, and 9's care plans revealed: *He was responsible for updating care plans. *Resident 3's care plan should have included information for antianxiety medication. *Resident 7's care plan should have included information for residing on the memory care unit, antipsychotic medication, and antidepressant medication.</p>	F 279	<p>appropriate quarterly and upon significant change". On 6/28/2016, DON reviewed and revised care plans for residents 3, 7, and 9. Care plans updated by DON to include: resident 3 takes antianxiety medication. Resident 7 resides on the Memory Care unit, takes antipsychotic medication and antidepressant medication. Resident 9's care plan updated to indicate that resident resides on Memory Care unit. Beginning 7/29/2016, DON or her designee will review four care plans weekly to ensure that they are current and reflect resident's state and preference, and that they are accurate. This will occur weekly and report the results to the QAPI committee for as long as the committee determines necessary.</p> <p>→* The DON / Designee will JVE/SDDOH/JEL</p>	

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F 279	<p>Continued From page 12</p> <p>*Resident 9's care plan should have included information for residing on the memory care unit.</p> <p>Interview on 6/8/16 at 3:00 p.m. with the director of nursing revealed her expectations would have been for resident's 3, 7, and 9's care plans to have been updated to reflect their current status.</p> <p>10. Review of the provider's August 2013 Plan of Care policy revealed "An interdisciplinary plan of care is developed within seven (7) days after completion of the comprehensive MDS (minimum data set) assessment and is based upon the identification of the resident's condition and needs. The plan of care identifies problems, approaches, goals, and the services necessary to assist the resident in attaining the highest practicable level of functioning."</p> <p>Surveyor: 34030</p> <p>11. Random observations on 6/7/16 from 10:00 a.m. through 5:30 p.m. and 6/8/16 from 8:00 a.m. through 5:00 p.m. of resident 6 revealed she had a half-lap tray attached to her wheelchair on the left side.</p> <p>Interview on 6/7/16 at 11:55 a.m. with certified nursing assistant I regarding resident 6 revealed: *She came from another facility with the half-lap tray. *She needed help from staff to remove it.</p> <p>Review of resident 6's medical record revealed: *She had a diagnosis of left hemiplegia (left sided weakness) from a stroke and was unable to use her left arm. *There had been no initial or ongoing assessments for the use of the wheelchair</p>	F 279	<p>"Physical Restraint" policy and procedure reviewed by DON on 6/28/2016 and found to be accurate. On 6/29/2016 Dr.'s orders for lap tray for Resident 6 requested by facility. Restraint assessment form completed on 6/24/2016 by RN E. PT assessed on 6/30/2016 and determined that upon facility assessment, resident was capable of lifting half lap tray</p>	

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F 279	<p>Continued From page 13 half-lap tray. *There had been no physician's order for the use of the wheelchair half-lap tray. *There was no documentation on her care plan about the half-lap tray to show she used it.</p> <p>Review of resident 6's 6/2/16 Minimum Data Set assessment revealed she had a Brief Interview for Mental Status assessment (mental thinking assessment) of fifteen that showed she was able to think for herself.</p> <p>Observation on 6/7/16 at 4:30 p.m. of resident 6 with the half-lap tray revealed: *She was unable to remove it when asked by this surveyor. *Her left arm lay limply on top of the tray. She could not move both her left arm and the tray with her right hand.</p> <p>Interview on 6/9/16 at 10:00 a.m. with the director of nursing regarding resident 6 revealed: *There had been no assessment or physician's order for the use of the wheelchair half-lap tray. *She had not considered the tray to be a restraint. -"The resident came [to this facility] with it." -She used it for positioning her left arm and had requested it. *The resident was cognitively aware of it but could not physically lift the tray up and down. *She confirmed the wheelchair half-lap tray should have been assessed for its use and care planned appropriately.</p> <p>Review of the provider's 8/11/12 Physical Restraint Policy and Procedure policy revealed: ***Physical restraints are any method or physical or mechanical device, material, or equipment attached to the resident's body that the individual</p>	F 279	<p>independently. Resident informed on 6/30/216 of risk involved with using the half lap tray. Resident indicated understanding and desire to keep lap tray. Care plan updated 6/29/2016 to indicate resident's ability to use lap tray sometimes, and other times the inability to lift the tray. Beginning 7/9/2016, resident will be assessed weekly by floor nurse to ensure resident is able to lift lap tray independently. DON or her designee will verify monthly that weekly assessment has taken place, and results of audit will be reported to QAPI quarterly for as long as the committee determines necessary.</p> <p>All nursing staff educated 6/29/2016 by DON regarding the following policies: "Resident Dignity", "Plan of Care", and "Physical Restraint". Specifically, staff educated by DON to ensure understanding that resident has a right to participate in their the care plan must articulate resident preference, such as upholding resident's right to dignity through respecting resident's preference of caregiver's gender.</p>	

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F 279	Continued From page 14 cannot remove easily, which restricts freedom of movement or normal access to one's body; this includes waist, vest, pelvic restraints, hand mitts, wheel chair safety bars, lap boards, geri chairs with trays, wheelchair belts and bed siderails that cannot be released easily by the resident". **If restraints are in use at the time of admission: -A. Complete restraint assessment form carefully assessing the resident and environment. -B. Obtain a consultation with the Physical Therapist for further assessment and for the recommendation of the least restrictive interventions. -C. Inform resident and/or family member in writing of the risks involved with restraint use. -D. Obtain a physician's order including the type of restraint or protective device and when it may be used. -E. Monitor resident carefully and document findings."	F 279			
F 323 SS=E	Surveyor: 34030 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: 29354 Based on observation, interview, and policy	F 323		7/29/16	

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F 323	Continued From page 15 review, the provider failed to ensure storage of chemicals were secured on four of four observed housekeeping carts in four of four neighborhoods (Maple Valley, Willow Wood Way, Cotton Wood Court, and Plum Creek) by two of two observed housekeepers (C and D). Findings include: 1. Observation on 6/7/16 and on 6/8/16 at the following times in the listed neighborhoods revealed: *On 6/7/16 at: -11:00 a.m. and 11:42 a.m. in Maple Valley (memory care unit) outside of resident 22's room was a housekeeping cart with several spray bottles of chemicals stored on top of it. There was no housekeeper in attendance of that cart. -11:45 a.m. in Plum Creek was a housekeeping cart outside of empty resident room PC9 with several spray bottles of chemicals stored on top of it. There was no housekeeper in attendance of that cart. --11:50 a.m. in Willow Wood Way was a housekeeping cart parked in the middle of the hallway outside of the supply room with several bottles of chemicals stored on top of it. There was no housekeeper in attendance of that cart. -11:52 a.m. housekeeper C had left a housekeeping cart with several bottles of chemicals stored on top of it unattended in the hallway as she went into the supply room. *On 6/8/16 at: -9:25 a.m. and 9:30 a.m. in Willow Wood Way was a housekeeping cart outside of resident 23's room with several spray bottles of chemicals stored on top of it. There was no housekeeper in attendance of that cart. -9:52 a.m. in Cotton Wood Court was a housekeeping cart with several spray bottle of chemicals stored on top of it in the middle of the	F 323			

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F 323	<p>Continued From page 16 hallway by the utility room. There was no housekeeper in attendance of that cart.</p> <p>Observation and interview on 6/8/16 at 9:55 a.m. in Cotton Wood Court with housekeeper D revealed: *A housekeeping cart with several spray bottles of chemicals stored on top of the cart in the middle of the hallway by the utility room. Housekeeper D had come out of the utility room. Interview at the above time revealed she: -Had just gone into the utility room to get something for the cart. -Usually had the cart positioned against the wall with the chemicals on top of the cart closest to the wall. -Had never taken the housekeeping cart into the resident's room, because there had not been room. -Could have stored the chemicals in a locking compartment on the housekeeping cart but usually had the housekeeping cart within her eyesight. -Confirmed she had been sweeping the floor at 9:25 a.m., and the cart was not in her view at that time.</p> <p>Interview on 6/8/16 at 1:30 p.m. with the environmental services director regarding chemicals being unsecured on the housekeeping carts revealed his expectations would have been for the chemicals to have been stored in the cabinet of the housekeeping cart when staff were not present.</p> <p>Interview on 6/8/16 at 3:00 p.m. with the director of nursing regarding the chemicals being unsecured on the housekeeping carts revealed: *Her expectations would have been for the</p>	F 323	<p>F 323</p> <p>"Storage of Cleaning Products" policy reviewed by Admin. and Environmental Services Director on 6/28/2016 and added the following "Cleaning products placed on a housekeeping cart must be locked in the locked compartment when not in use." Personal in-servicing provided to Housekeepers C and D on 6/29/2016 by the Environmental Services Director regarding appropriate storage of cleaning chemicals. All staff educated by DON/ Environmental Services Director on 6/29/2016 about survey findings, the revised "Storage of Cleaning Products" policy, and each team member's role and responsibility to ensure resident safety with appropriate storage of chemicals. Beginning 7/29/2016, cleaning carts will be monitored daily by Environmental Services Director or his designee to ensure chemicals are stored and locked safely. Reports will be made by the Environmental Services Director to the QAPI committee quarterly for as long as the committee determines necessary.</p>		

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F 323	Continued From page 17 chemicals to have not been left unattended. *Chemicals should never have been left unattended in the memory care unit.	F 323		
F 371 SS=E	Review of the provider's revised 9/5/13 Storage of Cleaning Products policy revealed: "Cleaning products that are not in use are stored behind closed and locked doors. Cleaning products that are being used to clean the facility are kept away from residents and close to the staff person that is working with them to clean the facility." 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, product specifications, and policy review, the provider failed to ensure: *Pasteurized eggs were used for soft cooked eggs in three of four neighborhoods (Plumb Creek, Cottonwood Court, and Maple Valley) for 6 randomly observed residents (16, 17, 18, 19, 20, and 21). *The thaw date was labeled on 18 Mighty Shakes and 1 Magic Cup (nutritional supplements for	F 371		7/29/16

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F 371	<p>Continued From page 18 extra calories and protein) in 2 of 4 neighborhoods (Willow Wood and Plumb Creek). Findings include:</p> <p>1a. Observation on 6/8/16 at 7:18 a.m. in the Plumb Valley neighborhood revealed: *One and one-half flats (thirty eggs per flat) of uncatheterized shell eggs in the kitchen's refrigerator. *Eggs were being prepared in a fry pan on the kitchen's stove top.</p> <p>Interview at the above time and location with certified nursing assistant (CNA) G revealed she: *Was preparing the eggs for residents 16 and 17. *Stated resident 16 liked her eggs "over easy." *Stated resident 17 preferred her eggs a "little runny."</p> <p>b. Observation on 6/8/16 at 7:40 a.m. in the Cottonwood Court neighborhood revealed approximately one-half flat of unpasteurized shell eggs located on the counter next to the kitchen's stove top.</p> <p>Interview at the above time and location with CNA and medication aide (MA) H revealed three residents 18, 19, and 20 preferred their fried eggs prepared soft and not firm.</p> <p>Interview on 6/8/16 at 7:45 a.m. with residents 18 and 19 in the Cottonwood Court's dining room revealed both: *Had received fried eggs. *Preferred them a "little runny."</p> <p>Interview at the same time and location as above with resident 20 revealed she: *Had received fried eggs.</p>	F 371			

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F 371	<p>Continued From page 19</p> <p>*Preferred her eggs soft and not hard.</p> <p>c. Observation on 6/8/16 at 8:00 a.m. in the Maple Valley neighborhood revealed approximately one and one-half flats of unpasteurized shell eggs located in the kitchen's refrigerator.</p> <p>d. Interview at the same time and location as above with CNA, MAA revealed resident 21 that preferred her eggs over easy and with a soft yolk.</p> <p>Interview on 6/8/16 at 8:30 a.m. with the dietary manager revealed: *The eggs located in the neighborhoods were not pasteurized. *The eggs were cooked as the resident's preferred them and included runny yolks, over easy, and soft cooked eggs. *He agreed the eggs needed to have been thoroughly cooked and firm, as they were not using pasteurized eggs. *Staff preparing residents' requests for soft cooked and undercooked eggs needed to have used pasteurized shell eggs or liquid pasteurized eggs.</p> <p>Review of the provider's 2013 Meat and Vegetable Preparation policy revealed only pasteurized eggs may have been used for soft cooked eggs.</p> <p>2a. Observation on 6/7/16 at 8:32 a.m. in the Plumb Creek neighborhood kitchen's refrigerator revealed: *One four ounce (oz) Magic Cup container without a thaw date indicated. *Without a thaw date there was no way to ensure when the Magic Cup had been thawed.</p>	F 371	<p>"Meat and Vegetable Preparation" policy reviewed by Dietary Manager and Registered Dietician on 6/28/2016 and was updated with the following "pasteurized eggs will be used for all cook to order eggs at breakfast." Personal inservicing provided by RD to DM before 7/29/2016 to ensure understanding of this policy. On 6/10/2016, DM removed all unpasteurized eggs and replaced them with pasteurized eggs, which are now consistently and solely being used in preparing breakfast. Beginning 7/29/2016, DM will monitor that pasteurized eggs are being used to serve breakfast once each week and report findings to that QAPI committee for as long as the committee determines necessary.</p> <p>All dietary and nursing staff educated by DM on 6/29/2016 about the updated "Meat and Vegetable Preparation" policy, and the importance of using pasteurized eggs.</p>	

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F 371	<p>Continued From page 20</p> <p>b. Observation on 6/7/16 at 11:20 a.m. in the Willow Wood neighborhood kitchen's refrigerator revealed: *Eighteen Mighty Shakes, four fluid oz containers, without a thaw date indicated. *Without a thaw date there was no way to ensure when the shakes had been thawed.</p> <p>Observation at the above time and location revealed a handwritten sign on the refrigerator with the following: "Mighty Shakes expire 14 days from thawing. Magic Cups expire 5 days from thawing. Please date when they are put in fridge. Thank you!"</p> <p>c. Interview on 6/8/16 at 8:30 a.m. with the dietary manager revealed: *The thaw dates for the Magic Cup and the Mighty Shakes needed to have been written on the containers. *He confirmed that without thaw dates there was no way to ensure when the products had been thawed.</p> <p>Review of the provider's 2013 Food Storage policy revealed: *All foods were to have been labeled and dated. *All foods would have been checked to ensure that foods were consumed by their safe use by dates or discarded.</p> <p>Review of the provider's undated product specifications for the Magic Cup revealed: *Shelf life was one year when kept frozen. *Shelf life was five days when kept refrigerated.</p> <p>Review of the provider's undated product specifications for the Mighty Shakes revealed:</p>	F 371	<p>"Food Storage" policy reviewed on 6/28/2016 by DM and found to be accurate. All mighty shakes and magic cups identified in this survey were disposed of by DM by 6/9/2016. Nursing and dietary staff educated on 6/29/2016 by DM about the freeze/thaw dates, the policy, and the importance of dating all items in refrigerators. DM will conduct twice weekly audits beginning 7/29/2016 to ensure that all items in fridges on neighborhoods are properly dated. Results will be delivered to QAPI committee by DM and monitors will continue as long as the committee determines necessary.</p>		

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F 371	Continued From page 21 . *Shelf life was one year when kept frozen. *Shelf life was fourteen days when kept refrigerated.	F 371		
F 431 SS=D	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 instructions, and the expiration date when applicable. 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. 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.	F 431	F 431 "Medication Administration and Return of Unused Medications" policy reviewed by DON on 6/28/2016 and found to be accurate. Personal inservicing provided by DON to RN J on 6/29/2016 to ensure understanding of properly storing all drugs and biologicals in locked compartments. Beginning 7/29/2016, random observation audits will be completed by DON or her designee to ensure medication and treatment carts are secure when unattended three times each week and reported to the QAPI committee for as long as the committee determines necessary. Education regarding the importance of locking medication and treatment carts provided by DON to nursing team on 6/29/2016.	7/29/16

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F 431	Continued From page 22 This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to ensure one of four medication carts in one of four neighborhoods (Cotton Wood Court) was secured. Findings include: 1. Observation on 6/7/16 from 12:30 p.m. through 12:45 p.m. revealed: *A medication cart located by the dining area in Cotton Wood Court had been left unlocked and unattended. *Registered nurse (RN) J who was assigned to that neighborhood was not present during the above time. Interview on 6/7/16 at 12:50 p.m. with the director of nursing (DON) revealed she would have expected the cart to be locked: *When a nurse leaves an area. *Each time after medications had been set-up for administration to each resident. Interview on 6/7/16 at 6:20 p.m. with RN J revealed she: *Confirmed she had left the cart unlocked and unattended during the above observation time. *Had been in a hurry to go to lunch that day and forgot to lock it. *Routinely had left the cart unlocked while administering medications unless she left the area. Interview on 6/8/16 at 4:05 p.m. with the DON confirmed she considered an unlocked	F 431			

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F 431	Continued From page 23 medication cart as unattended when a nurse turned her back to the cart to deliver medications to resident.	F 431		
F 441 SS=D	<p>Review of the provider's 9/13/15 Medication Administration and Return of Unused Medications policy revealed medication carts "Must be locked when unattended."</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (3) The facility must require staff to wash their hands after each direct resident contact for which</p>	F 441		7/29/16

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F 441	<p>Continued From page 24</p> <p>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: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure hand hygiene and clean dressing change procedures had been maintained for one of three sampled residents (9) by two of five observed staff (A and B) during the resident's personal care. Findings include:</p> <p>1. Observation on 6/8/16 at 8:50 a.m. in resident 9's room revealed: *Certified nursing assistants (CNA)/unlicensed assistive personal (UAP) A and B had entered the resident's room. The resident had been laying in bed. *Without performing hand hygiene they both put on a pair of gloves. *CNA/UAP A put underwear, socks, and pants on the resident. *CNA/UAP B opened a package of Mepilex border sacrum dressing and layed the opened package on the bedside table. *CNA/UAP A repositioned the resident in bed towards her. *CNA/UAP B took three wet wipes from a package and layed the wipes on the bed next to the resident.</p>	F 441	<p>F441</p> <p>"Hand Washing" policy reviewed by DON on 6/28/2016 and updated to reflect the requirement of washing hands for at least 20 seconds. CNA/UAPs A & B will be provided personal inservicing with return demonstration by DON or RN N (Infection Control Nurse) regarding this policy by 7/29/2016. A QAPI monitor of random observation audits assessing appropriate use of gloves and proper handwashing will begin 7/29/2016 and will be conducted twice weekly as long as QAPI determines necessary. All staff educated regarding this policy on 6/29/2016.</p> <p><i>*The DON / Designer will complete the audits and report to QAPI on a quarterly basis. JVE/SD/DH/EL</i></p>		

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F 441	<p>Continued From page 25</p> <ul style="list-style-type: none"> *CNA/UAP B removed a soiled pad from the resident and then took the wet wipes and cleaned the resident. *CNA/UAP A discarded the soiled pad into the garbage can. *Both CNA/UAPs assisted the resident with sitting up on the edge of the bed. *CNA/UAP A took a glass of water and offered her a drink. *Both CNA/UAPs A and B: <ul style="list-style-type: none"> -Positioned the mechanical lift sling behind the resident and attached the sling to the lift. -Positioned the leg strap behind the resident's lower extremities. -Transferred the resident with the lift to the toilet. *CNA/UAP A removed her gloves and without performing hand hygiene put on a new pair of gloves. *CNA/UAP B removed her gloves, washed her hands, and put on a new pair of gloves. *CNA/UAP A and B assisted the resident with the mechanical lift to a standing position by the toilet. *CNA/UAP A: <ul style="list-style-type: none"> -Took three wet wipes and cleaned the fecal matter from the resident buttock. -Applied a barrier cream to the buttock area. -CNA/UAP B handed the Meplilex border sacrum dressing to CNA/UAP A who then applied the dressing to the resident's sacral region. *Both CNA/UAPs put a clean pad on the resident, pulled up her slacks, and transferred her to the wheelchair with the mechanical lift. *CNA/UAP A removed her gloves and washed her hands. <p>Review of resident 9's medical record revealed:</p> <ul style="list-style-type: none"> *A diagnoses of dementia, glaucoma, anxiety, and history of urinary tract infections. *The 2/25/16 and 4/13/16 quarterly Minimum 	F 441		
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F 441	<p>Continued From page 26</p> <p>Data Set (MDS) assessments revealed she was at risk for skin breakdown, required assistance with transfer, dressing, hygiene, and toileting, and was frequently incontinent of bowel and bladder.</p> <p>*She had a history of skin breakdown in the perineal and buttock regions.</p> <p>*The Braden scale (used to determine skin breakdown) had been coded as high.</p> <p>*The revised 6/29/15 care plan focus area documented she had mixed bowel and bladder incontinence and a history of urinary tract infections.</p> <p>*A 6/3/16 physician's order for Mepilex border dressing to the sacral area one time a day every three days.</p> <p>Interview on 6/8/16 at 3:00 p.m. with the director of nursing (DON) regarding resident 9 revealed her expectations would have been for the CNA/UAPs to have performed hand hygiene and changed gloves during the above procedure.</p> <p>Interview on 6/9/16 at 9:20 a.m. with the DON and registered nurse (RN) N regarding resident 9 revealed:</p> <p>*RN N had done infection control audits as part of the infection control process for the facility.</p> <p>*Both agreed the CNA/UAPs should have performed hand hygiene and changed gloves during the above procedure.</p> <p>Review of the provider's undated Hand Washing policy revealed:</p> <p>*"The following are instances when hand washing must be done:</p> <ul style="list-style-type: none"> -Before and after caring for each resident. -After handling used dressings, urine, bedpans, or assisting the resident in the bathroom." 	F 441			

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F 441	Continued From page 27 Review of the provider's 9/4/14 Non-Sterile Dressing Change policy revealed: **Procedure: -Wash hands thoroughly. -Apply non-sterile gloves. -Cleanse wound according to physician order."	F 441		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
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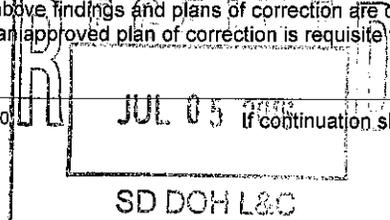
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K 000	INITIAL COMMENTS Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 new health care occupancy) was conducted on 6/9/16. Bethany Home - Brandon was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for New Health Care Occupancies upon correction of the deficiency identified at K050 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	*Addendums noted with an asterisk per 7/20/16 per telephone with facility administrator. JB/SDCOHJEL	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to complete the observed fire drill in the Plum Creek Neighborhood according to their written fire plan. Findings include: 1. Observation at 10:30 a.m. on 6/9/16, revealed	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jane Quirkson TITLE: Administrator (X6) DATE: 7/1/2016

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



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K 050	Continued From page 1 the staff person responding to the simulated fire in the Plum Creek Neighborhood required the maintenance supervisor to tell her every step of the procedure on conducting a fire drill. Interview with the maintenance director at the time of the observation indicated that all staff personnel had the drill procedure written on the back of their identification badge. He agreed the staff person conducting the drill needed further training. That deficiency had the potential to affect all residents and staff located within this neighborhood during an actual fire emergency.	K 050	K 050 Fire plan was reviewed by Maintenance Director and Admin. on 6/29/2016 and was found to be accurate. Staff person re-educated with return demonstration by Maintenance Director by 7/29/2016 regarding Fire Plan. Beginning 7/29/2016, Fire Drills will be conducted by Maintenance Director twice a month for 2 months with results being reported by the maintenance director to QAPI committee for as long as the committee determines necessary. <i>* the quarterly JB/SDDOH/EL</i>	7/29/16

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10677-2	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
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S 000	Compliance/Noncompliance Statement Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 6/7/16 through 6/9/16. Bethany Home - Brandon was found not in compliance with the following requirement: S210.	S 000		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35121 Based on record review, interview, and policy review, the provider failed to ensure two of five sampled employees (K and L) had a completed health evaluation within fourteen days of being	S 210		

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

TITLE

(X6) DATE

Jane Gullickson

Administrator

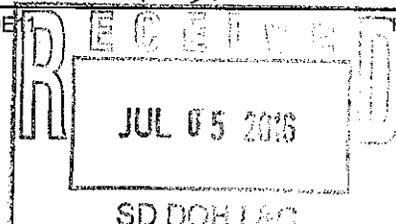
7/1/16

STATE FORM

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continuation sheet 1 of 2



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10677-2	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2016
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S 210	Continued From page 1 hired. Findings include: 1. Review of the following employees' personnel records revealed: *Employee K had been hired on 3/18/16. *Employee L had been hired on 2/8/16. *There was no signed documentation in the above employees' personnel files of a health evaluation for free of communicable disease having been reviewed and signed by a health care professional. Interview on 6/8/16 at 3:20 p.m. with the administrator regarding employee K and L's personnel files confirmed: *A health care provider had not signed the records indicating they had been reviewed to have been free from communicable disease. *The evaluations had not been completed within fourteen days of being hired. Review of the provider's revised 9/17/09 Employee Health Evaluation policy revealed "All new employees must be evaluated by an RN [registered nurse] prior to assignment to duties, to assure that they are free of a communicable disease."	S 210	S 210 "Employee Health Evaluation" policy reviewed by the DON on 6/28/2016 and was found to be accurate. Employee files for Employees K & L were reviewed and signed by DON on 6/9/2016. All other employee health files will be reviewed by 7/29/2016 by DON or her designee to ensure compliance. Beginning 7/29/2016, HR Manager will notify DON of new hires immediately upon hire. Also beginning 7/29/2016, cheHR manager will monitor new employee health files twice monthly to ensure that health evaluation has been signed by DON or her designee. HR manager will report results of this audit to QAPI committee quarterly for as long as the committee determines necessary.	7/29/16
S 000	Compliance/Noncompliance Statement Surveyor: 29354 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training program, was conducted from 6/7/16 through 6/9/16. Bethany Home - Brandon was found in compliance.	S 000		