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

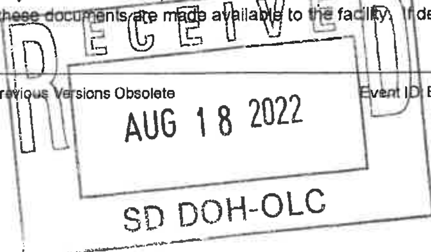
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435071	A. BUILDING ______ B. WING ______	07/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	**129 W HWY 12** **WEBSTER, SD 57274**

(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
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/26/22 through 7/28/22. Bethesda Home was found not in compliance with the following requirements: F686 and F908.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance with the State Operations Manual.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (29) had interventions in place to prevent a pressure ulcer from developing under a splint. Findings include: 1. Observation on 7/26/22 at 8:45 a.m. of resident 29 revealed: *She was sitting in her wheelchair at a table in the dining room. *Her left leg was in a splint that was wrapped with an ACE bandage and was elevated on her	F 686	F686 Completion Date: 8/18/2022 1. All RN's and LPN's were re-educated by the Director of Nursing/Director of Nursing Designee on 8/15/22 regarding the importance of proper assessments, interventions and documentation of pressure sores. Resident 29 along with all residents with pressure sores were reviewed by the Director of Nursing/ Director of Nursing Designee on 8/15/22 to make sure all care plans and interventions were in place. 2. All residents could be affected. 3. All RN's and LPN's were re-educated by the Director of Nursing/Director of Nursing Designee on the importance of making sure pressure sores have proper assessments, interventions, and documentation on 8/15/22. 4. Audits monitoring all pressure sore documentation/care planning will be performed by the Director of Nursing/ Director of Nursing Designee weekly x2, bi-weekly x2, monthly x1 then brought to the Quality Assurance Committee monthly for further recommendations.	8/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	8/18/22

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 686	Continued From page 1 wheelchair leg. Observation and interview on 7/26/22 at 11:00 a.m. with registered nurse (RN) D in resident 29's room revealed: *She and a CNA had transferred resident 29 from her bed to her wheelchair. *"We use a Hoyer lift (mechanical lift) for all transfers since her fibula fracture. *She has a Stage II pressure ulcer that started as two small blisters on the left shin, under the brace. The splint is removed once a shift to observe the skin." Observation on 7/26/22 at 4:00 p.m. of resident 29 revealed: *She was lying on her back in bed. *She had the appearance of being asleep - her eyes were closed. *Her left leg was in a splint that went from knee to ankle with the top of it open and it went around her foot at the heel. *The splint was wrapped with an ACE bandage. Review of resident 29's 6/23/22 quarterly MDS (Minimum Data Set) assessment indicated her BIMS (Brief Interview for Mental Status) score was zero, indicating severe cognitive deficit. Review of resident 29's medical record revealed: *Her diagnoses had included: -Vascular dementia without behavioral disturbances. -Primary generalized osteoarthritis. -Fracture of left fibula (7/14/22). The 7/18/22 progress note indicated, "Two fluid filled blisters were noted under splint on left leg" (in splint for left fibula fracture).	F 686		

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F 686	Continued From page 2 *RN I had "Discovered the blisters after unwrapping [the splint] to assess skin and rewrapping." -"Area was padded and splint with ACE wrap reapplied." The 7/18/22 "wound management detail report" identified the blisters as a Stage II pressure ulcer with measurements of: *"Lateral [side] of shin measured 5 centimeters (cm) by 2 cm. -Medial [middle] shin measured 3 cm by 2 cm." A 7/25/22 progress note revealed: *RN I had unwrapped the ACE bandage and removed the splint. -The blisters were intact. -The blisters were padded with a 4 x 4 gauze dressing and rewrapped. The 7/25/22 "wound management detail report" indicated measurements of the blisters were: *"Lateral [side] of left shin was 5 cm by 0.5 cm. -Medial [middle] of left shin was 3 cm by 0.1 cm." --These were the only progress notes about resident 29's pressure ulcer. Interview on 7/27/22 at 10:00 a.m. with RN/nurse manager C regarding resident 29 revealed her ACE bandage and splint on her left leg were to have been removed once a shift to assess skin. Voiced "It isn't always documented." Observation and interview on 7/27/22 at 4:15 p.m. with RN D revealed she unwrapped the resident's ACE bandage and splint from left leg. Blisters remained intact. RN D did not measure the blisters. She then rewrapped the splint.	F 686		

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F 686	Continued From page 3	F 686		

Interview on 7/28/22 at 9:55 a.m. with director of nursing B revealed, "The nurses are unwrapping the ACE wrap and removing resident's leg splint once a shift and assessing skin."
*When told I had only seen documentation of two narratives and measurement notes regarding removing the ACE bandage and splint in resident's progress notes, she agreed the documentation piece was missing and said, "We could do something to make it better."
*She and RN/nurse manager C have discussed skin issues and pressure ulcers and the documentation piece of those and are working on a solution.

Review of resident 29's 7/15/22 care plan revealed:
*Problem start date of 7/15/22 - "Has fracture to left fibula. Currently nonweight bearing to left leg."
*The goal was that resident would return to her prior level of functioning at resolution of fracture.
*Approaches included:
-"Has splint to left lower leg. Keep splint in place at all times.
-Monitor CMS [circulation, motion, sensation] and pulses of the affect [affected] extremity.
-Elevate left lower extremity.
-Monitor for increase in swelling or pain of affected extremity-notify nursing staff as noted/needed.
-Weight bearing status - Nonweight bearing to left leg.
*Has pressure areas to left lower extremity related to splint, see EMAR [electronic medication administration record] for treatment/monitoring."
-This intervention had been added to her care plan on 7/22/22.
-Monitor skin integrity with all cares and activities, reporting to nursing staff any concerns noted.

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F 686	Continued From page 4 --There were no instructions on how this was to occur. --The care plan did not address how often to unwrap and rewrap the ACE bandage to observe the skin around the splint. Review of provider's 6/1/19 Prevention of Skin Breakdown Policy #NH1 revealed the purpose was to prevent the development of pressure ulcers. The prevention methods were: *All residents would be assessed upon admission, readmission, and every shift for the presence of any skin impairment, and any type of wound, including pressure ulcers. *Observe patient [resident] for reddened or blanched areas over pressure sites, especially rim of ears, shoulder blades, elbows, sacrum, hips, knees, ankles, and heels. *Observe for skin integrity during patient's [resident's] bath or whenever care was given to the patient [resident]. Review of the provider's 6/1/19 Skin Issue (Bruise, Skin Tear/Laceration, Rash/Lesion, Pressure Injury/Ulcer) Policy revealed they were to add a Nursing Order to monitor wound every shift. Then add another, separate Nursing Order to assess wound weekly.	F 686		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure safe	F 908		

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F 908	Continued From page 5 operation of the dietary department's electrical stove top burner by four of four dietary staff for three of three observations. Findings include: 1. Observation on 7/26/22 from 8:48 a.m. to 9:01 a.m. of cook G in the kitchen revealed: *She removed a frying pan from the right front stovetop burner. She did not turn off the burner before she walked into the dining room, thereby leaving the burner unattended. *The burner dial was set between the "very lo" and "med lo" settings. *By 9:01 a.m., the burner was still turned on and remained unattended. Surveyor informed dietary manager (DM) E of the situation. DM E turned the burner off by turning the dial to the "off" position. 2. Interview on 7/26/22 at 9:01 a.m. with DM E revealed she: *Started her position less than a year ago. *Did not know at first the cooks often left the burners on. *Stated it was an ongoing issue with her staff. *Needed to reeducate staff about kitchen safety. 3. Observation on 7/27/22 from 8:10 a.m. to 8:15 a.m. in the kitchen revealed: *The right front stovetop burner was turned on and unattended. *The dial was set to "high." *Dietary aide H, cook F, and DM E walked by the stovetop burner several times. None of them turned the burner off. *At 8:15 a.m., cook F turned the burner off. 4. Observation on 7/27/22 at 9:19 a.m. revealed the right front burner was turned on and unattended. The burner dial was between the "med lo" and "med high" setting.	F 908	F908 Completion Date: 8/18/2022 1. Staff members F and D were immediately re-educated by the Dietary Director on 7/27/22 with regard to turning off the burner when they are not using it. 2. All residents could be affected. 3. All Dietary staff were re-educated by the Dietary Director/Dietary Director Designee on 8/15/22 regarding the importance of turning off the burner when it is not in use. 4. Audits monitoring burner use will be performed by the Dietary Director/ Dietary Director Designee weekly x2, bi-weekly x2, monthly x1 then brought to the Quality Assurance Committee monthly for further recommendations.	8/18/22 IG

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F 908	Continued From page 6 5. Interview on 7/27/22 at 11:48 a.m. with DM E revealed: *Leaving the burner on and unattended was a serious safety issue. *It was an ongoing reeducation topic with her employees. 6. Interview on 7/28/22 at 9:31 a.m. with administrator A revealed he: *Was unaware of the issue with leaving the burners on and unattended. *Agreed that leaving the burners on and unattended was a serious safety issue. *Was going to mention the topic at the provider's next quality improvement meeting. 7. Review of the provider's policy titled "Equipment Safety" revealed: *The policy was part of the 2017 "Becky Dorner & Associates, Inc." policy and procedure manual, section 6-4. *Procedure number nine stated, "Equipment should not be left on when unattended."	F 908		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 7/26/22 through 7/28/22. Bethesda Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 8/18/22

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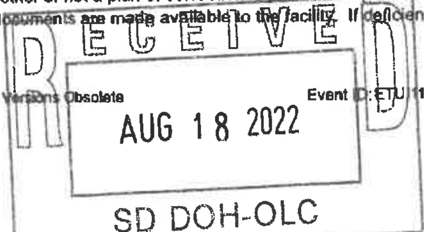

South Dakota Department of Health

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	10706	A. BUILDING B. WING	07/28/2022

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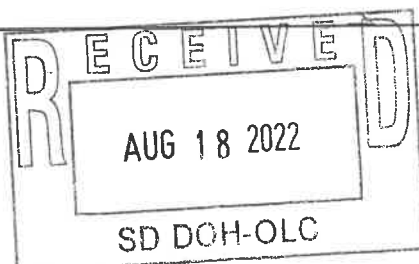
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/26/22 through 7/28/22. Bethesda Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/26/22 through 7/28/22. Bethesda Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 8/18/22



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	435071	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	07/26/2022

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/26/22. Bethesda Home was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222 and K226 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222	8/18/2022 K 222 Completion date- 8/18/22 1. Accept this as the facility's credible allegation of compliance. 2. The egress door in the boiler room had a new door handle installed on 7/26/22. 3. The facility Maintenance Director/ Designee will conduct 1x monthly audit on the door for three months. 4. The Quality Assurance Committee will monitor the boiler egress door on a monthly basis for the length of three months.	8/18/22 IG

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Administrator
(X6) DATE: 8/18/22

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K 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the	K 222		

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K 222	Continued From page 2 provider failed to provide operable egress doors as required at one randomly observed exit door location (boiler room emergency exit door). Findings include: 1. Observation on 7/26/22 at 1:45 p.m. revealed the boiler room emergency exit door was unable to be opened. Testing of the door revealed it would not open without applying greater than one hundred pounds of force in the direction of the path of egress. The cause was later determined to be faulty door hardware. The interview at the time of the observation with the maintenance director confirmed those conditions. He stated he was unaware that the door was not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected staff working in the boiler room or in the kitchen storage room. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
K 226 SS=F	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5	K 226		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435071	A. BUILDING **01 - MAIN BUILDING 01** B. WING	07/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	**129 W HWY 12** **WEBSTER, SD 57274**

(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 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the fire-resistive design of one of one horizontal exit/building separation wall (between the nursing home and the hospital). Findings include: 1. Observation on 7/26/22 at 11:45 a.m. revealed the two-hour, fire-rated separation wall between the nursing home and the hospital had ninety-minute, fire-rated metal doors and appropriate wall construction above the doors. Two penetrations had been made above the doors for the computer cabling, one 2-inch, and one 4-inch penetration had not been sealed to maintain the fire separation. Interview with the maintenance supervisor at the time of observation confirmed that condition. The deficiency could affect 100% of the occupants of the smoke compartment.	K 226	K 226 Completion date- 8/18/22 1. Accept this as the facility's credible allegation of compliance. 2. The penetrations in the fire wall were fixed by maintenance staff on 7/27/22. This reestablished the fire separation between the hospital and nursing facility. 3. The facility Maintenance Director/ Designee will conduct one monthly audit, for the length of a three months. 4. The Quality Assurance Committee will monitor the fire wall 1x monthly basis for the length of three months.	8/18/22 IL