STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

(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 Surveyor: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/5/21 through 10/7/21. Bethesda of Beresford was found not in compliance with the following requirements: F582, F657, F676, F679, F686, F688, F725, F813, and F880. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/5/21 through 10/7/21. Areas surveyed included quality of care and resident rights. Bethesda of Beresford was found not in compliance with the following requirements: F657, F676, F679, F686, F688, F725, and F880.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582	Resident 23's record cannot be timely updated to include the Skilled Nursing Advanced Beneficiary Notice of Non-Coverage (SNF ABN). Social Services, MDS, and Business office staff will be re-educated by the Administrator on 10/27/21 on the facility's policy for "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) form CNA-10055 to ensure compliance skilled stays for residents and timely notification. Administrator or designee will monitor residents requiring notices weekly X 4 weeks then monthly X 2 months.	11/04/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Britney Senger
TITLE: Administrator - EPH
(X6) DATE: 10/29/21

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 582	Continued From page 1 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on record review and interview, the provider failed to ensure the proper Medicare notice was provided for one of three sampled	F 582	Administrator or designee will present findings from these audits at the monthly QA committee for review until the QA committee advises to discontinue monitoring.	

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F 582	Continued From page 2 residents (23) who had remained in the facility following her discharge from skilled services. Findings include: 1. Resident 23's last day of Medicare part A services were 4/8/21. *She had covered days remaining and continued to reside in the facility. *There was no record of a signed Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). -This standardized notice allows Medicare beneficiaries to make informed decisions about whether to received certain Medicare services and accept financial responsibility for those services if Medicare does not pay. Interview on 10/6/21 at 10:18 a.m. with licensed social worker (LSW) D regarding resident 23's SNFABN revealed: *She should have completed the SNFABN. *It was an oversight and she had not completed the SNFABN. Review of the "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CNA-10055 (2018)" provided by regional director A revealed: *"Medicare requires SNFs [skilled nursing facilities] to issue the SNFABN to Original Medicate, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance..."	F 582		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657	Resident 34's care plan was updated by the MDS Coordinator on 10/26/21 to include but not limited to offering call lights within reach, identification of pressure ulcers and wounds as well as interventions on prevention	11/04/21

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F 657	Continued From page 3 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to have an updated and revised care plan for one of fourteen sampled residents (34) to reflect their current needs. Findings include: 1. Observations on the following dates and times of resident 34 revealed on: *10/5/21 at: -9:16 a.m. she was lying on her back in bed, both eyes were closed, the head of the bed was	F 657	for skin breakdown, offering one-on-one activities, interventions on fall precautions and precautions on what to do for seizure activity. MDS Coordinator reviewed all other resident's care plans were reviewed and revised to include, but not limited to, offering call lights within reach, identification of pressure ulcers and wounds as well as interventions on prevention for skin breakdown, interventions on fall precautions and what to do for seizure activity. All residents have the potential to be affected by this deficient practice. DON and interdisciplinary team review and revised, as necessary, the policy and procedure ensuring complete and accurate care plans on 10/26/21. DON or designee provided education to all staff responsible for creation, review, implementation, and revision of resident care plans on 10/27/21. DON or designee will also offer education to interdisciplinary team for Patient Centered Comprehensive Care Plan guidelines on 10/27/21. DON or designee will perform audits on care plans to reflect current health conditions for 5 residents weekly for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meetings for review.	

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F 657	Continued From page 4 elevated 25 degrees, and she had pressure-relieving boots on both feet. -12:43 p.m. she was sitting up in the recliner in her room and had the pressure-relieving boots on both feet, and the call light was on the floor under the bed. --She did not have any way to notify staff if she needed anything. -3:45 p.m. and at 4:00 p.m. she was lying in bed with the television turned to cartoons. *10/06/21 at: -8:44 a.m. and 9:40 a.m.: --She was lying in bed on her back. --The lights were off, and the curtain was pulled. --In the bathroom on a shelf beside the sink was an emesis basin. ---In that emesis basin were two tubes of toothpaste and a toothbrush with the date 8/5 on it. ---The toothbrush bristles were dry without any residue. --The toothbrush appeared to not have been used. -10:50 a.m. she was up in the recliner in her room. --She did not have the protective heel boots on. ---One was located on her bed and one was on the dresser. --She did not have any protective pressure relieving footwear on. -1:50 p.m. she was in bed on her back with protective heel boots on. --The call light was draped across her nightstand and not within her reach. *She had not been observed out of her room on 10/5/21 and on 10/6/21. *There had been no observations of staff providing one-to-one's in her room or offering any type of in-room activity except for having the	F 657		

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F 657	Continued From page 5	F 657		

television on with cartoons playing.
*There had been two observations where she did not have the protective heel boots on.
*There were two observations where the call light had not been within her reach.

Review of resident 34's medical record revealed:
*An admission date of 8/8/17.
*Diagnoses of severe intellectual disabilities, epilepsy, and seizures.

Review of the 9/21/21 quarterly Minimum Data Set (MDS) assessment revealed:
*She had:
-A history of falls.
-Two or more falls since admission.
-A risk for developing pressure ulcers.
-Not been coded as having any skin issues.
-Interventions of a pressure relieving device in bed and the chair, but no other interventions.
- A Brief Interview for Mental Status (BIMS) examination score of three indicating severe cognitive deficit.
-Required extensive assistance of two staff for bed mobility.
-Required total assistance of two staff for transfer, dressing, toilet use, and personal hygiene.

Review of the nursing progress notes on the following dates for resident 34 revealed on:
*8/1/21 at 10:44 p.m.:
-The nurse had been called into her room at 5:40 p.m.
-She was lying on the floor on her back horizontally in front of the recliner.
-The recliner was all the way up.
-The bedside table was by her head, with her feet towards her bed.

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F 657	Continued From page 6	F 657		

-The call light was on the floor by her feet.
-She had on socks.
-The call light had not been on.
*9/4/21 at 3:34 p.m.:
-She was found in her room on the floor next to the recliner.
-There was a remote on the arm of the chair.
-She unable to tell the nurse what happened.
-She had been incontinent of bowel and bladder at the time of the fall.
*On 10/4/21 a pressure ulcer/deep tissue injury had been identified on her right heel.
-"Area is suspected deep tissue injury."
-"Right heel has suspected deep tissue injury measuring 4 centimeters (cm) by 4 cm, area is not blanchable, area is not open, under skin is purple in places. Nursing will apply skin prep BID [twice daily] and keep heel boats on at all times for prevention."
*The undated physician's order revealed "Skin prep R) heel, leave mepilex heel protector on and secure with paper tape after each skin prep application - done BID - Heel protectors on at all times."

Review of resident 34's 9/19/21 care plan revealed:
*ADL [activities of daily living].
-Skin:
--"I am at risk for pressure ulcers related to incontinence, decreased activity level, tube feeding and impaired mobility.
--I have a pressure reducing cushion on my w/c and a pressure reducing mattress.
--Monitor my skin daily with cares and alert nursing to any areas of concern.
---There were no skin assessments in the medical record to indicate if there were any skin concerns.

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F 657	Continued From page 7	F 657		

-- Heel boots on at all times."
---The heel boots had been observed to be off her feet twice during the above observations.
-Activities:
--"I enjoy watching some t.v. programs especially cartoons.
--I like music and enjoy the different entertainers who come to perform.
--Staff has been good to me they visit with me in the common area.
--I do go to senior sports where we play kick ball, balloon volleyball and sometimes we even bowl.
--I do come to morning devotions when I feel up to it.
--I do like to sit in the common area and watch people coming and going.
--I am enjoying my one on one with staff."
-Activities of daily living:
--Dental: "I have my own teeth and need your assistance in caring for them."
-Safety: "I am at risk for fall requiring staff assistance, incontinence, impaired mobility, impaired decision making have diagnosis epilepsy-if I am having a seizure follow precautions and alert the nurse."
*There were no:
-Precautions on what to do for seizure activity.
-Interventions on fall precautions.
-Interventions on prevention of skin breakdown.
--On 10/4/21 a deep tissue injury had been documented.
*She had not been observed out of her room on 10/5/21 or on 10/6/21.

Interview on 10/7/21 at 10:50 a.m. with interim director of nursing/MDS coordinator C regarding resident 34's care plan revealed:
*The care plan had not been updated to reflect her current needs.

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F 657	Continued From page 8 *She was involved with updating the care plans. *They did not have any interventions in place before she developed the deep tissue injury on her right heel. -She would have expected her to have received oral care. --The date on the toothbrush 8/5 was probably when it had been placed in her room. -They would have expected her to receive some sort of one-to-one activities. -She would tell the staff "no" when she did not want to come out for scheduled activities. --She said no a lot even though her BIMS score was 3. --Some staff would have sat with her in her room. -There were no documentation activities or one-to-ones had been done. -They would expect staff to be involved with her activities. Interview on 10/7/21 at 9:40 a.m. with licensed social worker D regarding resident 34 revealed: *She loved to watch TV. *She did not: -Like to be around a lot of people. -Like to be around new people. *She had not been in to visit resident 34 this week. Review of the provider's 7/14/17 Care Planning Process policy revealed: *"Purpose: To insure a comprehensive, individualized plan of care for each resident." *Policy: -Using an interdisciplinary approach each resident will have an individualized plan of care which addresses the resident's needs and severity of condition, impairment, disability, or disease and based on the universal care	F 657		

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F 657	Continued From page 9 standards identified by the [facility name] staff as the minimum standards for all residents."	F 657		
F 676 SS=E	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including	F 676	Administrator, Interim DON, and interdisciplinary team reviewed and revise as necessary the bath policy and procedure to ensure residents receive a weekly bath/shower on 10/26/21. Resident 9 and resident 33's bath schedule was reviewed and revised on 10/26/21 to include a minimum of one bath/shower per week is completed and overseen by the Interim DON to ensure compliance. All other resident's bath schedule was reviewed and revised on 10/26/21 to ensure that a minimum of one bath/shower per week is completed and overseen by the Interim DON to ensure compliance. DON or designee will provide education to all staff responsible for giving baths/showers to ensure all resident's needs are met at a minimum of once per week on 10/27/2021. For all staff that were not present for the in-service, will be educated prior to their next scheduled shift. DON or designee will perform audits on the bathing schedule for completion for 5 residents weekly for four weeks and monthly for two more months. LSW will conduct resident counsel on 11/3/21 to follow-up on the satisfaction of baths and report any concerns to the DON.	11/04/21

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F 676	Continued From page 10 (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure four of four sampled resident's (9, 33, and two of two confidential resident interviews) had received regular bathing. Findings include: 1. Interview on 10/5/21 at the following times with licensed practical nurse (LPN) H regarding the facilities bathing schedule revealed at: *7:50 a.m.: -The bath aide: --Would be giving baths from 2:00 p.m. through 4:00 p.m. today. --Had been scheduled to come to work at 2:00 p.m. *2:26 p.m.: -The bath aide would take her "spot" when she was done with baths at 4:00 p.m. -Confirmed the time frame for baths today (10/5/21) was only two hours. 2. Observation and interview on 10/5/21 at 2:35 p.m. with resident 33 and certified nursing assistant (CNA) I during resident 33's bath revealed: *Resident 33 confirmed she: -Had been getting a bath weekly but in the past few weeks it had "been longer." -Felt they were doing what they could to accommodate her. *CNA I: -Worked as a bath aide when they needed her to. -They had a bath list they went by.	F 676	DON or designee will present findings from these audits at the monthly QAPI meeting for review.	

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-If they were not able to bath a resident on their scheduled bath day, they would try to have a staff member come in over the weekend on Saturday or Sunday, or else try to get someone from the evening shift to come in early and do baths.

3. Interview with resident 9 on 10/6/21 at 7:35 a.m. regarding baths revealed:
*She did not have a regular bath day.
*They had not told her when her regular bath day was going to be.
*She wished she had a regularly scheduled bath day.
*Sometimes she would go two weeks without a bath.
*It bothered her to not get a bath.

4. Confidential resident interviews with two residents revealed:
*Their only concern was with bathing.
*They did not always receive a weekly bath.
*Their bath could be anytime during the week.
*They were short-staffed.
*They had not been told when their scheduled bath day was.
*They were not getting their nails trimmed.
*"It could go up to two weeks without getting a bath."

5. Review of resident 9's bath schedule and confirmed by the interim director of nursing (DON)/Minimum Data Set (MDS) coordinator C on 10/6/21 at 4:40 p.m. regarding resident 9's bathing schedule revealed from 9/6/21 through 10/6/21 she had received three baths out of a possible five times.

6. Random record review of the two confidential resident interviews regarding bathing from 9/6/21

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435080	A. BUILDING ______ B. WING ______	C 10/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	**606 W CEDAR** **BERESFORD, SD 57004**

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F 676	Continued From page 12 through 10/6/21 revealed: *One resident had received two baths out of a possible five times. *One resident had recieve four baths out of a possible five times. 7. Review of the facility bath schedule revealed the residents were scheduled to receive one bath per week. 8. Interview on 10/7/21 at 8:40 a.m. with interim DON/MDS coordinator C and administrator B regarding bathing of residents revealed: *Resident 9 should have received a weekly bath. *They: -Needed the staff on the floor to do quality of care for the residents first. -Had tried to have someone come in and fill in for baths. Review of the provider's undated Bath policy revealed: *"Purpose/Policy: -To cleanse the skin. -To provide comfort for the resident. -To observe the condition of the skin."	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of	F 679	Resident 34's care plan was reviewed and revised on 10/27/2021 by the MDS Coordinator to provide an ongoing program to support resident preference in their choice of activities, including offering one-on-one activities. All other residents care plans will be reviewed and revised to provide an ongoing program to support resident preference in their choice of activities.	11/04/21

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F 679	Continued From page 13 each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (34) who was cognitively impaired was involved in an activity program based on her assessed interests and needs. Findings include: 1. Observations on the following dates and times of resident 34 revealed on: *10/5/21 at: -9:16 a.m. she was lying on her back in bed, both eyes were closed, the head of the bed was elevated 25 degrees. The curtain was closed and the room was dark. -12:43 p.m. she was sitting up in the recliner in her room. -3:45 p.m. and at 4:00 p.m. she was lying in bed with the television turned to cartoons. *10/06/21 at: -8:44 a.m. and 9:40 a.m.: --She was lying in bed on her back, the lights were off, and the curtain was closed. -10:50 a.m. she was up in the recliner in her room. -1:50 p.m. she was in bed on her back. *She had not been observed out of her room on 10/5/21 or on 10/6/21. *There had been no observations of staff providing one-to-one's in her room or offering any type of in-room activity with her except for having the television on with cartoons playing. Review of resident 34's 10/5/21 care plan revealed:	F 679	Administrator, Interim DON, and interdisciplinary team reviewed and revised as necessary the activities department policy on 10/27/21. DON or designee will provide education* to the activity department and all staff responsible for creating an individualized and comprehensive assessment of each resident's ongoing program of activities. DON or designee will perform audits on the ongoing activity program to ensure it meets the interests and needs of the physical, mental, and psychosocial well-being on 5 residents weekly for four weeks and monthly for two more months. DON or designee will present findings from these audits at the monthly QAPI meeting for review. *, on 10/27/21, BS 11/1/21	

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F 679	Continued From page 14	F 679		

*"I love music, bead-work, animals and babies. Grease is my favorite movie and I love listening to my Grease CD. I am Congregational and attended a UCC Church. I love to visit if you take your time with me."
*APPROACH per resident 34's care plan:
-"ACTIVITIES - I enjoy watching some t.v. programs especially cartoons and I like to watch sports especially football. I like music and enjoy the different entertainers who come to perform. Staff has been good to me they visit with me in the common area. I do go to senior sports where we play kick ball, balloon volleyball and sometimes we even bowl. Staff helps me so I can participate and I do have fun. I do come to morning devotions when I feel up to it. I do like to sit in the common area and watch people coming and going. My family is good to me they make sure I have nice clothes to wear and visit me often. I do nap every afternoon one hour or longer. I am enjoying my one on one time with staff. GOAL: Stay happy and healthy at [Facility name]."

Review of resident 34's medical record revealed:
*There were no activities documented.
*The 8/4/21 through 10/4/21 progress notes had not included any documentation regarding activities.
*The 9/21/21 quarterly Minimum Data Set assessment had coded:
-The Brief Interview for Mental Status Examination score three indicating she was severely cognitively impaired.
-She had unclear speech, the ability to understand her, or respond to her was "sometimes understood."

Interview on 10/7/21 at 8:40 a.m. with interim

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F 679	Continued From page 15 director of nursing (DON)/Minimum Data Set (MDS) coordinator C and administrator B regarding resident 34's activity program revealed: *They would have expected her to receive some sort of one-to-one activity. -She would tell the staff "no" when she did not want to come out of her room for activities. --"She says no a lot even though her BIMS score was 3." --Some staff will sit with her in her room. -There was no documentation that activities or one-to-one's had been done. -They would expect staff to be involved with her activities. *They were currently without an activity director but had two activity assistants. Interview on 10/7/21 at 9:40 a.m. with licensed social worker D regarding resident 34's activity program revealed: *She: -Loved to watch television. -Did not like to be around a lot of people. -She did not like to be around new people. *She was aware they did not have an activity director. -The new activity assistants were new. *She had not been in to visit resident 34 this week. Review of the provider's 10/6/21 Activities Department policy revealed: *"Facility will provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental, and psychosocial well-being of each resident."	F 679		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686	Resident 34's care plan was reviewed and updated on 10/26/2021 by the	11/04/21

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F 686	Continued From page 16 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: Surveyor: 29354 Based on observation, interview, record review, and policy review, the facility failed to ensure two of two sampled residents (15 and 34) with facility acquired pressure ulcers and one of one sampled resident (35) with a history of pressure ulcers had: *Ongoing skin assessments. *Implemented individualized interventions to prevent skin injuries. *Updated care plans for the prevention of pressure ulcers. Findings include: 1. Observations on the following dates and times of resident 34 revealed on: *10/5/21 at: -9:16 a.m. she was lying on her back in bed, both eyes were closed, the head of the bed was elevated 25 degrees, and she had pressure relieving boots on both feet.	F 686	MDS Coordinator to include head-to-toe skin assessments and documentation of repositioning. Resident 15 and 35's care plan was reviewed and updated on 10/29/21 by the MDS Coordinator to include head-to-toe skin assessments and documentation of repositioning. All other residents care plans with a high risk of compromised skin integrity will be reviewed and updated to include head-to-toe skin assessments and documentation of repositioning.* Administrator, Interim DON, and interdisciplinary team reviewed and revised as necessary the policy and procedure for skin integrity, and pressure ulcer prevention policy on 10/26/21. DON or designee will provide education to all staff about their roles and responsibilities for prevention of pressure ulcers on 10/27/21. CNAs will report any new skin issue to their charge nurse. Licensed nurses will report any new skin issue based on each resident's weekly skin assessment, or observations from the CNA, to the MDS Coordinator for the resident's care plan to be updated. DON or designee will audit proper pressure ulcer prevention and treatment twice per week for four weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 686	Continued From page 17 -12:43 p.m. she was sitting up in the recliner in her room, had the pressure relieving boots on both feet, and the call light was on the floor under the bed. --She did not have any way to notify staff if she needed anything. -3:45 p.m. and at 4:00 p.m. she was lying in bed with the television turned to cartoons. *10/06/21 at: -8:44 a.m. and 9:40 a.m.: --She was lying in bed on her back, the lights were off and the curtain was pulled. -10:50 a.m. she was up in the recliner in her room. --She did not have the protective heel boots on. ---One was located on her bed and one was on the dresser. --She did not have any protective pressure relieving footwear on. -1:50 p.m. she was in bed on her back with protective heel boots on. *There had been two observations where she did not have the protective heel boots on. Review of resident 34's medical record revealed: *The pressure ulcer/stasis ulcer had been identified on her right heel on 10/4/21. *They were documenting it as a deep tissue injury. *There had not been any skin assessments completed for the past 30 days. *The undated physician's orders stated was to "have the heel protectors on at all times." *There was not any documentation as to how often she had been repositioned. Review of resident 34's 10/4/21 care plan revealed: *Start date: 10/4/21:	F 686	BS 11/1/21 * by the MDS Coordinator.	

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F 686	Continued From page 18 -Approach: --Skin - Braden score = 14 (Risk assessment scale used to determine skin breakdown. A score of 13 - 14 indicates moderate risk). --"I am at risk for pressure ulcers related to incontinence, decreased activity level, tube feeding and impaired mobility. --I have a pressure-reducing cushion on my W/C and a pressure reducing mattress. --Monitor my skin daily with cares and alert nursing to any areas of concern. --I have a pressure ulcer to my right heel-see TAR (treatment assessment record) for treatment. --Heel boots on at all times. --Braden monthly and PRN (when necessary)." -GOAL: "to be free from skin issues." There were no interventions on the care plan for preventing a pressure ulcer. Review of resident 34's quarterly 9/21/21 Minimum Data Set (MDS) assessment had been coded: *Being at risk for developing pressure ulcers. *Not having any skin issues. *Had included interventions of a pressure relieving device in bed and the chair but nothing else. *Required extensive assistance of two staff for bed mobility. *Required total assistance of two staff for transfer, dressing, toilet use, and personal hygiene. *The Brief Interview for Mental Status examination score was three indicating severe cognitive impairment. Interview on 10/7/21 at 10:50 a.m. with interim director of nursing (DON)/MDS coordinator C	F 686		

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F 686	Continued From page 19 regarding resident 34's skin issues revealed: *They did not have any interventions in place prior to the deep tissue injury discovered on 10/4/21. *She should have worn the protective heel boots at all times. *They had not documented head-to-toe skin assessments. *They had not documented when residents were repositioned. Surveyor: 41895 2. Review of resident 15's medical record revealed: *Her Braden scale score, which is used to predict the risk of developing a pressure ulcer, on 7/15/21 was 12, indicating she was at high risk. *She had developed a pressure ulcer on her right toe on 7/17/21. *Her care plan did have interventions in place to assist in the prevention of a pressure ulcer. *There had been no documentation of head-to-toe skin assessments in her medical record. Interview on 10/06/21 10:42 a.m. with interim DON C regarding resident 15 revealed: *The pressure ulcer had been caused by her shoes rubbing. *Since the development of the pressure ulcer, she had been wearing gripper socks, and no other pressure ulcers had developed. 3. Observations on 10/5/21 from 8:30 a.m. through 1:00 p.m. revealed she had been sitting in her wheelchair (w/c). Observations on 10/6/21 from 7:50 a.m. through 1:49 p.m. of resident 35 revealed she had been sitting in her w/c.	F 686		

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F 686	Continued From page 20 *She had a cushion on her w/c. Interview on 10/6/21 at 1:49 p.m. with certified nursing assistant (CNA) E regarding resident 35 revealed: *She had not been out of her chair since she had been assisted into it for breakfast. *She was incontinent of bowel and bladder, and needed to be assisted into bed to have her incontinence brief changed. *CNA E agreed she had not had her incontinence brief changed since prior to breakfast. Review of resident 35's 9/23/21 care plan revealed: *Her Braden scale score was 16, indicating she had been at mild risk for developing a pressure ulcer. *She had a history of pressure ulcers to her bilateral heels and buttocks. *A pressure reducing w/c cushion and an air mattress. *She liked to sit in the recliners in the common area. *She refused to be changed and repositioned at times. *Needed education on the "importance of offloading pressure." *The goal was "To not have any new skin breakdown." 4. Interview on 10/5/21 at 1:28 p.m. and on 10/6/21 at 10:34 a.m. with interim DON C regarding pressure ulcers and skin assessments revealed: *A licensed nurse does not do a formal head-to-toe skin assessment on a regular basis. -Agreed that having a nurse do a regular head-to-toe skin assessment could prevent the	F 686		

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F 686	Continued From page 21	F 686		

development of a pressure ulcer.
*CNAs observed skin during cares or bathing and let the nurse know if there was an issue.
-Then the nurse would assess and document the skin concern.
*If a resident had a pressure ulcer only the ulcer area was assessed and documented weekly.
*She expected residents to be repositioned about every two hours.
*Repositioning of residents was not documented.

5. Review of the provider's 1/8/19 Pressure Ulcer Prevention policy revealed:
*"Purpose:
-To promote the prevention of pressure ulcer development
-To promote the healing of pressure ulcers that are present including prevention of infection to the extent possible
-To prevent the development of additional pressure ulcer."
*"Pressure Ulcer Prevention Strategies:
-Based upon resident assessment and consideration of clinical condition, choices and identified needs, basic and routine care may include the following interventions:
--1. Redistribution of pressure (repositioning, protect heels, special mattresses, offloading or floating heels)
--2. Minimization of skin exposure to moisture and keep skin clean, especially of fecal contamination (incontinence barriers, toileting schedules, use of absorbent incontinence products)
--3. Maintaining or improving nutrition and hydration status (passing of snack and hydration carts, increase supplements in food provided, dietician consults)."

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F 686	Continued From page 22 On 10/5/21 at 5:30 p.m. a policy regarding skin integrity was requested. On 10/6/21 at 8:00 a.m. interim DON C stated they did not have a policy.	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation, interview, and record review, the provider failed to ensure 3 of 14 sampled residents (9, 31, and 34) had received an ongoing restorative program. Findings include: 1. Observation on 10/5/21 at 10:42 a.m. of resident 31 in his room revealed he was in his Broda chair with the TV on. He was alert and appeared to focus on the TV program, but only responded verbally with a "yeah" or "no" to questions. Surveyor asked the resident to open	F 688	Unable to address the timely documentation in September for Residents 9, 31, and 34. Resident 9, 31, and 34 will be put on an active and ongoing restorative program assisted with staff. This program will begin on 11/1/21 under the supervision of the therapy department to assist residents. All residents have the potential to be affected by this deficient practice. * DON or designee will provide education to all staff and the therapy department about their roles and responsibilities for an active and ongoing restorative program to prevent a decline in a residents' activities of daily living on 10/27/21. DON or designee will audit documentation and implementation of the restorative programs twice per week for four weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review. * The MDS Coordinator will be monitoring residents who may need to be on a restorative nursing program. BS 11/1/21	11/04/21

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F 688	Continued From page 23	F 688		

and close his left hand and the resident responded appropriately by closing his left hand into a fist and opening it. Surveyor asked the resident to open and close his right hand, but the resident did not close or open his right hand. Resident's right hand appeared contracted.

Review of resident 31's medical record revealed:
*An admission date of 6/26/19
*Diagnoses that included: Multiple sclerosis, Major depressive disorder, peripheral vascular disease, osteoarthritis, and vascular dementia.
*A 7/5/19 physician order for restorative AROM (active range of motion) UE (Upper Extremity)/LE (Lower Extremity) consisting of seated LE exercises and UE exercises using pulleys, bands, and reaching tasks to be done once a day between 6:00 a.m. and 6:00 p.m.
*A 7/5/19 physician order for restorative communication to "Engage resident and encourage to use more than one word responses. Voice exercises. Name objects" to be done once a day between 6:00 a.m. and 6:00 p.m.

Review of resident 31's most recent, 9/7/21 significant change in status MDS assessment revealed:
*A brief interview of mental status (BIMS) score of eight indicating moderate impairment.
*A ROM UE impairment on both sides
*A ROM LE impairment on one side

Review of resident 31's prior, 6/8/21 annual MDS assessment revealed:
*A BIMS score of nine
*A ROM UE with no impairment
*A ROM LE with no impairment

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F 688	Continued From page 24	F 688		

Review of resident 31's point of care (POC) Nursing Rehab Time Log for the month of September 2021 revealed for both the AROM and communication restorative programs there was no documentation for AROM or communication provided for twenty-seven out of thirty days.

Interview on 10/7/21 at 10:34 a.m. with certified nursing assistant G revealed she:
*Currently does not do any restorative programs.
*Had done restorative programs in the past, 3-4 months ago.
*Had worked with resident 31 on restorative programs in the past.
*Knew there was a restorative binder in locked room 414 with a restorative therapy sign.
*Did not know of any staff that was currently doing restorative programs.

Interview on 10/7/21 at 10:45 a.m. with administrator B revealed and confirmed she:
*Had worked both restorative programs with resident 31 on 9/26/21 in the past three months.
*Had noted resident 31 has declined over the last two to three weeks.
-Two to three word sentences have declined to one-word response.
-UE/LE had also declined "a lot in the last 2-3 weeks."
*Was the administrator of the facility as of Monday, 10/4/21.

Surveyor: 29354
2. Review of resident 9's medical record revealed:
*A 5/13/21 physician's order for:
-Upper extremity (UE) active range of motion (AROM) to include any activities that focus on UE strength and activity/standing.

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-Use two-pound dumb bells x 15 repetitions (reps) to all UE planes while seated or standing at her front wheeled walker (FWW).
-Use one pound weights to her UE for dowel exercises x 15-20 reps x all movements while seated.
-Use a green TheraBand x 15-20 reps x all motions as tolerated.
-Use pulleys x 7-10 minutes with one pound weights to each of her wrists.
-UE bike x 7-10 minutes.
-Any tabletop activity in standing up to 10 minutes.
-Lower extremity (LE) AROM - Nu-step 10 minutes at level 3.
-Seated LE exercises with two-pound weights and blue TheraBand.
-Standing exercises.
-Once A Day.
*There was no documentation she had completed any of the above exercises.

Review of resident 9's 7/14/21 care plan revealed:
*APPROACH:
-"RESTORATIVE - I am independent with dressing and ambulation with my FWW in my room and hallways.
-I worked with PT (physical therapy) and OT (occupational therapy).
-GOALS: Maintain upper extremity level of function in order to remain independent in facility."

Review of resident 9's 7/13/21 quarterly Minimum Data Set (MDS) assessment revealed:
*A Brief Interview for Mental Status (BIMS) examination score of thirteen indicating she was cognitive.

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F 688	Continued From page 26 *She was independent with most activities of daily living. *There were no days documented she had received restorative nursing. Interview on 10/06/21 at 7:35 a.m. with resident 9 regarding her restorative nursing program revealed she: *Did not know she had a physician's order for a restorative nursing program. *Had done some exercises in her room by herself, but no one had helped her with them. 3. Observations on the following dates and times of resident 34 revealed she had not received any form of a restorative nursing program on: *10/5/21 at 9:16 a.m., 12:43 p.m., 3:45 p.m. and 4:00 p.m. *10/06/21 at 8:44 a.m., 9:40 a.m., 10:50 a.m. and 1:50 p.m. Review of resident 34's medical record revealed a 7/13/20 physician's order for AROM and for passive range of motion (PROM) bilateral to her upper extremities and lower extremities. They were to: *Provide stretching for her right knee extension as tolerated. *Trunk mobility: -Provide tasks that require reaching forward and to side to improve trunk mobility. -To stretch her right knee extension as tolerated. *It was an open ended nursing restorative program. *There was no documentation she had received a restorative nursing program. Review of resident 34's 9/21/21 quarterly MDS assessment had been coded:	F 688		

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*She required:
-Extensive assistance of two staff for bed mobility.
-Total assistance of two staff for transfer, dressing, toilet use, and personal hygiene.
*She had not received any form of a restorative nursing program.

Review of resident 34's current care plan had not included a restorative nursing program.

4. Interview on 10/06/21 at 12:11 p.m. with interim director of nursing (DON)/MDS coordinator C regarding resident's 9 and 34 and a restorative nursing program revealed:
*They have not had a restorative nursing program for the residents since they had their first positive COVID-19 resident.
-That date was August 2020.
*She confirmed resident's 9 and 34 had not been on a restorative nursing program.
*There was no restorative nursing program documentation for resident's 9 and 34.
*They did not have a:
-Current restorative nursing program due to staffing.
-Restorative nursing program policy.
*They did not have a plan on how to move forward with a restorative nursing program.

Interview on 10/7/21 at 8:40 a.m. with interim DON/MDS coordinator C and administrator B regarding the restorative nursing program revealed:
*They did not have the resources to spare for a restorative nursing program.
*They needed the CNAs on the floor to provide quality of care to the residents.
*They agreed the restorative nursing program

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F 688	Continued From page 28 was important to prevent a decline in a residents' activities of daily living.	F 688		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, staff scheduling review, employee training, personnel file review, and policy review, the	F 725	CNA E was requested to not come back to the facility on 10/6/2021 due to performance issues. Resident 9 and resident 33's bath schedule was reviewed and revised on 10/25/21 to include a minimum of one bath/shower per week is completed. Resident 34's care plan was reviewed and updated on 10/26/21to provide an ongoing program to support resident preference in their choice of activities, including offering one-on-one activities.*All residents have the potential to be affected by this deficient practice. Administrator, Interim DON, and interdisciplinary team reviewed and revised as necessary the policy and procedure for staffing and updated the orientation packet for temporary workers. DON or designee will provide education to supervisory and management staff to ensure each department is sufficient with staffing on 10/27/21. Facility has a staffing plan in place to meet staffing requirements through the recruitment of new staff, increasing the work hours of current staff and utilizing agency staff and/or engaging in new business agreements with additional agencies as needed.	11/04/21

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F 725	Continued From page 29 provider failed to provide nursing and related services to meet the residents' needs in a manner that promotes each resident's rights and physical, mental, and social well-being for 36 of 36 residents. Findings include: 1. Observation and interview on 10/5/21 at 7:50 a.m. with licensed practical nurse (LPN) H in the dining room talking to resident 14 about his bath revealed: *She informed him the bath person would be in the facility at 2:00 p.m. to give showers. -The bath aide was scheduled to come in at 2:00 p.m. and also help them "catch up" with things. 2. Interview on 10/5/21 at 9:01 a.m. with certified nursing assistant (CNA) E as she was coming out of a resident's room revealed: *She was from a staffing agency. *This was her first day in the facility and she was scheduled to work the next day. *Her orientation to the facility had consisted of "Getting information from another staff member on what residents needed assistance and what residents were 'ornery.' *She had been given a care plan that she had in her pocket. *She had been in a resident room and had to wait 30 minutes for another staff member to assist her with the mechanical lift. *She was working as a CNA. 3. Observation and interview on 10/05/21 at 9:33 a.m. with regional director A confirmed he was working as a CNA on the floor. 4. Interview on 10/5/21 at 2:26 p.m. with LPN H confirmed the:	F 725	Concerns related to insufficient staffing are tracked through the facility grievance process. A report of grievances are addressed by management staff immediately until proper action is taken place. DON or designee will audit randomly competent residents to ensure sufficient staffing is addressed twice per week for four weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review. * MDS Cordinator is responsible for reviewing and updating the care plans. BS 11/1/21	

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*Bath aide was giving baths from 2:00 p.m. until 4:00 p.m. today.
*Bath aide would then take her place on the floor at 4:00 p.m.
*Time frame for baths on 10/5/21 was two hours.

5. Observation and interview on 10/5/21 at 2:35 p.m. with resident 33 and CNA I during resident 33's bath revealed:
*Resident 33 had been getting a bath weekly but in the past few weeks it had been longer, but they "were doing their best to accommodate her."
*CNA I confirmed if they were not able to give a resident a bath on their scheduled bath day they tried to have someone come in over the weekend on Saturday or Sunday or else they would try to get someone from the evening shift to come in and do baths.

6. Interview with resident 9 on 10/6/21 at 7:35 a.m. regarding baths revealed:
*She did not have a regular bath day.
*She wished she had a regular scheduled bath day.
*Sometimes she would go two weeks without a bath.
*It bothered her to not get a bath.

7. Observation and interview on the floor on 10/6/21 at 7:30 a.m. with interim director of nursing (DON)/Minimum Data Set (MDS) coordinator C regarding staffing revealed:
*There were three CNAs working the floor that day.
-Two of those CNAs were from a staffing agency.
*CNA G:
-Was the scheduled bath aide.
-Started her shift out by giving a few baths and then assisted on the floor doing morning resident

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F 725	Continued From page 31 personal care. -Would continue with giving residents baths until 4:00 p.m. *They tried to have all the shifts covered or else piece them together to get the staff. *They did not have a staffing policy. 8. Interview on 10/7/21 at 8:40 a.m. with interim DON/MDS coordinator C and administrator B regarding staffing revealed: *They were currently without an activity director (AD). -They had a new AD hired who was going to start on 10/18/21. -They had two activity aides. -They agreed resident 34 had not received one-to-one activities and should have. *The laundry aide had been ill for two weeks. -The interim DON C, administrator B, business office manager, and activity aide had been helping in laundry. -They had recently hired four to five new staff for housekeeping and laundry. --They were cross-trained and would work in both departments. *Dietary was working extra shifts. -They had a new evening cook and a new dietary aide hired. *The nursing department: -Needed a DON. -They had a new charge nurse start. -They would need one full-time and one part-time nurse position to be filled November 2021. *They could always use more CNAs. *The CNAs were cross-trained to give baths. -Some of the CNAs would come in early for their shift and give baths. *They did not have the resources to spare for a restorative nursing program.	F 725		

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F 725	Continued From page 32 -They needed the CNAs on the floor to provide quality of care to the residents. -They agreed the restorative nursing program was important to prevent a decline in a residents' activities of daily living. 9. Confidential interviews with staff during the survey regarding staffing revealed they felt: *Rushed with doing resident care. *There was not sufficient staffing to care for the residents. The survey dates were from 10/5/21 through 10/7/21. Refer to F676, F679, F686, and F688.	F 725		
F 813 SS=D	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation, interview, and policy review, the provider failed to ensure three of three residents (2, 26, 35), who had personal refrigerators were monitored for appropriate refrigerator temperature along with cleaning and monitoring of food dates in accordance with professional standards for food safety. Findings include: Observation and interview on 10/6/21 at 8:55 a.m. with dietary manager J revealed: *She had worked here 25 years.	F 813	The refrigerator for residents 2, 26, and 35 have been cleaned by the environmental staff on 10/27/21. The temperature log for all refrigerators has a working thermometer and temperature logs are up to date. Any food that was not dated and/or outdated was discarded. Any resident with a personal refrigerator has the potential to be affected by this deficient practice. A facility audit was completed 10/27/21 by environmental staff to review what residents have personal refrigerators in their rooms. The facility policy has been revised to reflect that maintenance will be responsible for personal refrigerators. Administrator or designee will educate	11/04/21

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F 813	Continued From page 33 *The nourishment fridge on the nursing unit was monitored by dietary staff. *Resident personal refrigerators: -Some residents had personal refrigerators in their rooms. -She was not sure how many there were. -Dietary staff was not responsible for monitoring the contents, cleaning, and temperatures of resident personal refrigerators. -She remembers the facility having a resident personal refrigerator policy in the past. -She thought resident refrigerators were addressed in the admission packet. Observation on 10/6/21 at 4:35 p.m. in resident 35's private room after receiving permission from resident 35 to enter her room and look inside her refrigerator, revealed a small, 20 inches tall refrigerator in her room that she stated her son had brought in. No temperature log was found on her refrigerator. The inside of the refrigerator contained: *No thermometer. *A dried sticky residue. *An opened bag of caramels that was not dated. *Four small containers of cut-up peaches that were not dated. *One small container of cut-up pears that were not dated. *A package of four containers of diced peaches. *A package dated 7/20/21 of four containers of mandarin oranges. *An opened, undated 20-ounce bottle of orange Gatorade. Observation and interview on 10/6/21 at 4:50 p.m. with resident 2 in his private room revealed a 33-inch tall refrigerator in his room. When asked about his refrigerator, he stated he kept his sodas	F 813	maintenance department regarding resident personal refrigerators on 10/27/21. Maintenance will also be responsible for the daily temperature logs, cleaning of refrigerators and also removing any foods per facility policy Monday – Friday. Nursing department will be responsible for the daily temperature logs, cleaning, removing outdated food on Saturday/Sunday. Administrator or designee will audit fridges for proper temperature, cleanliness, and remove outdated food weekly for four weeks and monthly for two more months. Administrator or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 813	Continued From page 34	F 813		

and leftover food in the refrigerator. No temperature log was found on his refrigerator.
The inside of the refrigerator contained:
*No thermometer.
*Plastic bottles of soda.
*One bottle of peach Lambic Belgium beer, with a warning label regarding alcoholic beverages.

Interview and observation on 10/7/21 at 10:22 a.m. with resident 26 in her room revealed a small 20 inch tall refrigerator in her room. No temperature log was found on her refrigerator.
The inside of the refrigerator contained:
*No thermometer.
*Plastic bottles of iced tea beverages.

Interview on 10/6/21 at 4:45 p.m. with evening shift certified nursing assistant (CNA) K revealed she:
*Had worked there 6 years.
*Had not recorded temperatures for resident personal refrigerators.
*Had not been trained to do any tasks with resident personal refrigerators.

Interview on 10/7/21 at 10:10 a.m. with licensed social worker (LSW) D revealed:
*Three residents have personal refrigerators.
*She is not aware of any policy for resident personal refrigerators.
*No information on resident personal refrigerators were in writing or included in the admission packet.
*When asked about personal refrigerators she verbally informed those asking that the family is responsible for cleaning and maintenance of the refrigerator.

Interview on 10/7/21 at 10:26 a.m. with director of

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F 813	Continued From page 35 environmental services L regarding resident personal refrigerators revealed he: *Was not aware of any policy for resident personal refrigerators. *Has not done inspections on resident personal refrigerators. *Did help with delivering a personal refrigerator to a resident's room in the past. Interview on 10/7/21 at 10:34 a.m. with day shift CNA G revealed: *She has worked there for over one year. *Day shift CNAs do not do any tasks with resident refrigerators. Interview on 10/6/21 at 4:25 pm with interim DON/MDS coordinator C, following a request for the policy on resident personal refrigerators revealed: *She was not aware of any policy on resident personal refrigerators. *She did not know how many residents had personal refrigerators. *There were no temperature logs for these personal refrigerators. *Nursing was not responsible for monitoring the contents, cleaning, and temperatures of resident personal refrigerators. Interview on 10/7/21 at 10:55 a.m. with administrator B revealed and confirmed: *She was unaware of any staff monitoring resident personal refrigerators. *There was no policy regarding resident personal refrigerators. Review of 5/31/18 policy regarding incoming foods from outside sources revealed: *Purpose: to ensure safe and sanitary storage,	F 813		

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F 813	Continued From page 36 handling and consumption of foods brought into the facility by resident's family and visitors. *Policy: it is the policy of Bethesda of Beresford to provide safe and sanitary storage and handling of foods brought in from the outside by family and visitors, and ensures staff assist residents to access and consume these foods. *Procedure includes: -Foods must be labeled with the resident's name and dated. -Food will be discarded after three days. According to the United States Public Health Service's 2013 Food and Drug Administration Food Code: *3-501.16 (A) Time/Temperature Control for Safety Food shall be maintained: (1) At 135 degrees Fahrenheit (F) or above [hot foods]. (2) At 41 degrees F or less [cold foods]. *3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking: (A) Refrigerated, prepared, and held food shall be clearly marked to indicate the date by which the food shall be consumed. . . or discarded when held at a temperature of 41 degrees F or less for a maximum of seven days.	F 813		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	Time cannot be turned back to a time prior to the identification for RN F and LPN M for the lack of appropriate hand hygiene opportunities, proper mask wearing, procedural technique with skin care and dressing change involving equipment, glove use, and securing medical records on resident 2, 15, 17, 34. Refuse container was placed in resident 17's room for proper disposal of personal protective	11/04/21

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BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

(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 880	Continued From page 37 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880	equipment on 10/8/2021. All residents have the potential to be affected if staff do not adhere to appropriate hand hygiene opportunities, proper mask wearing, procedural technique with skin care and dressing change involving equipment, glove use, and securing medical records. The administrator and DON in consultation with the medical director and infection control nurse will revise, create as necessary policies and procedures regarding appropriate hand hygiene opportunities, proper mask wearing, procedural technique with skin care and dressing change involving equipment, glove use, and securing medical records. RN F and LPN M and all other staff responsible for the above services will be reeducated by the Infection Control Officer on 10/27/21. Discussion for other system changes included collaboration with South Dakota Quality Improvement Organization with the Administrator on 10/28/2021 to identify other potential risk cause analysis. Competency step-by-step checklist will be performed on each licensed nurse to ensure facility standards and compliance have been met on 10/27/21. Orientation packet for new hires and temporary licensed staff will be required for tasks relating to wound dressing changes by the DON.	

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F 880	Continued From page 38 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, record review, and policy review, the provider failed to ensure infection control techniques were maintained by one of one registered nurse (RN) (F) and one of one licensed practical nurse (LPN) (M) during four of four observed residents (2, 15, 17, and 34) skin treatments. Findings include: 1. Observation and interview on 10/6/21 at 2:20 p.m. with RN F during a dressing change for resident 34 in her room revealed: *RN F had a face mask and goggles on. -The face mask had not covered her nose. *Without disinfecting the top of the medication cart or laying down a barrier she laid the Kling roll and tape on top of the medication cart. *She performed hand hygiene. *Left resident 34's medical record open on the computer.	F 880	DON or designee will audit effective infection control prevention for wound dressing changes across all shifts and ensure education and training has been completed during orientation along with demonstrated competency for any new personnel 4 times weekly for 4 weeks and monthly for two more months. DON or designee will present the audit findings at the monthly QAPI meetings for review.	

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F 880	Continued From page 39 *Went into resident 34's room. She: -Placed a paper towel on the overbed table. -Laid the tape and Kling roll on top of the overbed table. -Put on gloves. -Removed the heel protector from resident 34's right foot. -Took a pair of scissors out of her pocket and cut the Kling roll on her right foot. -Removed the Kling roll and discarded it into the garbage. -Wiped skin prep over her right heel. -Placed the heel foam over the right heel. -Took the clean roll of Kling roll and rapped her right heel with it. -Laid the unused Kling roll and scissors on the paper towel. -Took a piece of tape and placed it on the Kling roll. -Removed a pen from her pocket and wrote the date on the tape. -Put the pen back into her pocket. -Put her sock and heel protector back on. -Lowered the bed. -Threw the paper towel away. -Laid the scissors and the Kling roll on top of the nightstand without a barrier. -Removed her gloves and did not perform hand hygiene. -Picked up the Kling roll and tape and left the room. -Returned to the medication cart and without laying down a barrier placed the scissors and Kling on top of it. -Performed hand hygiene, opened the medication top drawer and placed the Kling roll and tape roll back into the medication cart. --She had not disinfected the scissors.	F 880		

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F 880	Continued From page 40 2. Observation on 10/6/21 with RN F during a skin treatment for resident 2 in his room revealed: *Performed hand hygiene and put on gloves. -Her face mask continued to be below her nose. *Without disinfecting the top of the medication cart or laying down a barrier she: -Removed the scissors from her pocket and without disinfecting it laid them on top of the medication cart without a barrier. -Took two packets of skin prep from the medication cart and the scissors from the top of the medication cart and went into his room. -Placed a paper towel on top of the overbed table. -Dropped one packet of the skin prep on the floor. --Picked up the dropped skin prep packet from the floor and placed it on the paper towel on the overbed table. -With those same gloves she removed his left lower leg heel boot. -Took one packet of skin prep and wiped it around his right stump. -Took another skin prep and wiped it on his left heel. -Put his left lower leg heel boot back on. -Discarded the garbage. -Removed her gloves and performed hand hygiene. Interview on 10/6/21 at 3:20 p.m. with RN F regarding the skin treatments for resident's 2 and 34 revealed she: *Had some breaches in infection control. *She should have: -Disinfected the top of the medication cart and laid a barrier down. -Disinfected the scissors after she took them out of her pocket. -Performed hand hygiene between going from a soiled to a clean area.	F 880		

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*She had some missed hand hygiene opportunities.
Surveyor: 41895
3. Observation and interview on 10/6/21 at 2:50 p.m. of RN F while performing a dressing change for resident 15 revealed she:
*Was at the treatment cart in the hallway preparing dressing supplies for the dressing change and had touched many surfaces on the cart.
*Set dressing supplies on top of the treatment cart without a barrier under them.
*Without performing hand hygiene, she had reached into a drawer with an open bag of bulk 4 x 4 gauze with her bare hands and pulled out a few of them.
*Used a wound cleaner, sprayed the 4 x 4 gauze, and set them on top of the treatment cart without a barrier underneath them.
*Performed hand hygiene, picked up the dressing supplies, entered resident 15's room, retrieved a paper towel, and set the dressing supplies on top of the paper towel on the bedside table.
*Put on a pair of gloves, cleaned the wound with the 4 x 4 gauze, and applied a small amount of Medihoney to the wound.
*Removed her gloves and returned to the treatment cart in the hallway.
*Without performing hand hygiene, she removed the keys from her pocket, unlocked the cart, and removed another dressing.
*Returned into the room, performed hand hygiene, and applied a pair of gloves.
*With those gloves on she removed a scissors from her right uniform top pocket which had also contained her keys.
*Used contaminated scissors to cut the dressing still in the package in half.
*With those same now contaminated gloves she

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applied the dressing to the wound and taped it in place.
*With those same contaminated gloves, she removed a marker from her left uniform top pocket, labeled the dressing, and put the marker back into her right uniform top pocket.
*Removed the remaining dressing change supplies from the bedside table, and put them into the garbage can along with her gloves.
*Picked up the scissors and the roll of tape she had used and returned to the treatment cart in the hallway.
*Set the tape and scissors on top of the treatment cart while she unlocked it.
*Put the roll of tape back into the treatment cart with other rolls of tape, and put the scissors back into her pocket.
*When discussing the observation she agreed:
-The top of her treatment cart was not a clean surface and she should have used a barrier under the supplies.
-The bulk 4 x 4 gauze could have been contaminated and should be kept in a sealed container.
-Her pockets were not clean and agreed she should not put her clean gloved hands in the pockets, or keep her scissors in her pockets.
-The roll of tape could have been contaminated from being in the room so she should not have put it back into the treatment cart.

4. Observation and interview on 10/7/21 at 9:24 a.m. of licensed practical nurse (LPN) M performing a dressing change for resident 17 revealed:
*He had used 4 x 4 gauze out of an open bulk package in the treatment cart.
*He set dressing supplies on the nightstand without a barrier under them.

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*There was no garbage can for staff to use to dispose of used PPE.
*He had left his computer screen open on the treatment cart and people in the hallway could have been able to see resident's private health information.
*He agreed the 4 x 4 gauze that was open in the cart could have been contaminated.
*He should have put down a barrier under the dressing supplies on the nightstand.
*He should have locked his computer screen when he was not using it.

5. Interview on 10/7/21 10:12 a.m. with interim DON C regarding the above observations and interviews revealed:
*She agreed the bulk 4 x 4's and continuous gauze roll should be kept in a sealed container and not just left open in the cart.
*Staff were expected to perform hand hygiene before and after glove use, and when moving from a dirty task to a clean task.
*RN F should have disinfected the scissors prior to using them and should not have kept them in her pocket.
*When dropping dressing supplies on the floor they should not be used for wound treatment.
*She expected nurses to use a barrier under the dressing supplies when preparing dressings and during a dressing change.
*She expected all staff to lock their computer screen to protect private health information when walking away from the computer.
*There should have been a separate garbage can in resident 17's room for disposal of personal protective equipment.

6. Review of the provider's reviewed 6/6/18 Hand Hygiene policy revealed:

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*"Hand hygiene is the single most important strategy to reduce the risks of transmitting organisms from one person to another or from one site to another on the same resident.
*Cleaning hands promptly and thoroughly between residents contact and after contact with blood, body fluids, secretions, excretion, equipment, and potentially contaminated surfaces is an important strategy for prevention healthcare-associated infections."
*"1. Hand Hygiene should be performed:"
-"Before and after resident contact, including dry skin contact."
-"After removing gloves."
-"Before and after contact with wounds."
-"Before handling sterile or clean supplies."
-"When moving from contaminated to clean sites or areas."

Review of the provider's revised 8/30/15 Wound Dressing Change Policy revealed:
*A barrier was to be used under dressing supplies.
*It only addressed washing hands before gathering dressing supplies and then after the dressing change was completed.
-Did not address performing when moving from a contaminated site to a clean site.
*Equipment such as scissors should be disinfected before and after use.

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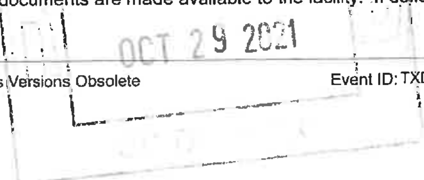
E 000	Initial Comments Surveyor: 41895 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 10/5/21 through 10/7/21. Bethesda of Beresford was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Britney Senger	Administrator - EPH	10/24/21

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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	435080	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/05/2021

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/5/21. Bethesda of Beresford 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 K223 and K920 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	The preparation of the following plan Of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain three randomly observed	K 223	Maintenance personnel or designee will address the kitchen service area roll down doors by removing the two wooden blocks. Staff will manually lift this service door. *The door leading into the dirty laundry storage area will have a self-closer. Room 112 will have a self-closer on the door. All other egress doors will be tested to ensure that they are operating effectively. Maintenance director or designee will audit all egress doors to ensure they are operating correctly weekly for 4 weeks and monthly for two months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. * Electrician, fire alarm consultants, and maintenance staff, will work in collaboration to resume functionality of the service door. The long term plan of serviciability, unknown of a realistic end-date for repair. Upgrading main fire panel, signed quote on 10/19/21 to allow capacity loads and options for the service roll down door. BS 11/1/21	11/04/21

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Britney Senger	Administrator - EPH	10/24/21

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K 223	Continued From page 1 hazardous areas (kitchen service area, soiled laundry, and storage room 112) as required. Findings include: 1. Observation on 10/05/21 at 10:15 a.m. revealed the kitchen service area was not able to maintain a smoke barrier. The fire system activated roll down door connecting to the dining area was held open with two wooden blocks. There have been documented ongoing attempts to appropriately link the door to the smoke detection system that began on 6/1/21. Thus far neither the door company nor the fire alarm company have successfully solved the issue. 2. Observation on 10/05/21 at 10:50 a.m. revealed the laundry was not protected by a self closing door to the dirty laundry storage area. The fire door separating the two areas had the bracket available, but no closer on the door. 3. Observation on 10/05/21 at 11:45 a.m. revealed room 112, previously used as a patient room and greater than 100 square feet, had large amounts of combustible storage within the space. The storage area was not protected by a self closing door as required. Interview with the plant operations manager at the time of these observations confirmed the findings. The deficiencies affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of each smoke compartment.	K 223		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920	Maintenance personnel or designee will address and remove the extension cord above the ceiling in the 400 wing corridor. *	11/04/21

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K 920	Continued From page 2 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to ensure electrical wiring and equipment was maintained in accordance with NFPA 70, the National Electrical code, in one randomly observed location (extension cord above the ceiling in 400 wing corridor). Findings include: 1. Observation on 10/05/21 at 1:45 p.m. revealed a randomly chosen voice over internet protocal phone system repeater in the 400 wing corridor had a transformer connected permanently to power via an extension cord above the ceiling.	K 920	All other areas in the ceiling will be addressed to ensure no other extension cords are used as a permanent alternative to wiring and removed from outlets and properly stored when not in use to avoid damage and potential circuit arcing. Maintenance director or designee will audit all phone system repeaters and ensure no extension cords are used and are removed from outlets and properly stored when not in use to avoid damage and potential circuit arcing weekly for 4 weeks and monthly for two months. Maintenance director or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring. * The VOIP was rewired on 10/28/21. After the extension cord was removed, the fire wall penetration left a void and was also recaulked. BS 11/1/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	10/05/2021

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K 920	Continued From page 3 The permanence of the connection was demonstrated by the cord being caulked at the firewall penetration. Extension cords are not an acceptable means of permanent wiring and should only be used on a temporary basis. They should be removed from outlets and properly stored when not in use to avoid damage and potential circuit arcing. Interview with the plant operations manager at the time of the observation confirmed that finding and the probability that this power connection method existed for the repeaters located throughout the building. He indicated he knew extension cords were not to be used as permanent wiring.	K 920		

South Dakota Department of Health

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	10595	A. BUILDING: ____ B. WING ____	10/07/2021

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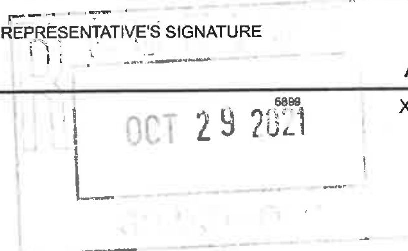
S 000	Compliance/Noncompliance Statement Surveyor: 41895 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/5/21 through 10/7/21. Bethesda of Beresford was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	The facility will review and revise the formal orientation program and the ongoing education program for all employees which cover the required subjects on an annual basis and include the required topic of abuse, neglect, misappropriation of resident property and funds, and mistreatment. Administrator and all staff responsible for hiring personnel will be re-educated on the initial orientation and ongoing, annual program. Administrator or designee will provide education to employee B and employee C to ensure completion of the required annual training of the 11 subjects. All other employees will be reeducated for proper completion of the annual training of the 11 subjects. Administrator or designee will audit employee files to ensure the required training occurs for all staff on payroll weekly for 4 weeks and monthly for two months. Administrator or designee will present findings from these audits at the monthly QAPI committee for review until the QAPI committee advises to discontinue monitoring.	11/04/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Britney Senger	Administrator - EPH	10/24/21



South Dakota Department of Health

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	10595	A. BUILDING: ______ B. WING ______	10/07/2021

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 44928 Based on personnel file review, interview, and policy review, the provider failed to ensure two of five newly hired sampled employees (B and C) received orientation training. Findings include: 1. Review of employee B's personnel file and orientation records revealed: *A hire date of 5/17/21. *There was no documentation of the required orientation training topics, (fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, resident rights, confidentiality of residents information's, incidents/disease reporting, dining assistance, nutritional risk, hydration, abuse, neglect, misappropriation, mistreatment and facility identified needs) found. 2. Review of employee C's personnel file and orientation records revealed: * A hire date 5/27/21. *There was no documentation of the required orientation training topics, (fire prevention/response, emergency procedures/preparedness, infection control and prevention, accident prevention/safety procedures, proper use of restraints, resident rights, confidentiality of residents information's, incidents/disease reporting, dining assistance, nutritional risk, hydration, abuse, neglect, misappropriation, mistreatment and facility identified needs) found.	S 206		

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S 206	Continued From page 2 Interview on 10/7/21 at 11:10 a.m. with administrator A confirmed the above orientation topics had not been completed by employees B and C. Review of the provider's 10/6/21 Staff Education and Competency policy and procedure revealed: *"They will provide, at minimum, eleven topics for on going educational programs. Every staff member is required to attend to be re-educated. If staff member is unable to make it to the meeting, handouts and /or competency checks will be required. These topics included: -1. fire prevention procedures and preparedness. -2. Infection control and prevention. -3. Accident prevention and safety procedures. -4. Proper use of restraints, patient and resident rights. -5. Confidentiality of patient or resident information. -6. Incident and diseases subject to mandatory reporting and the facility's reporting mechanisms. -7. Care of patients or residents with unique needs; medication administration, residents dependent on supplemental oxygen. -8. Dining assistance, nutritional risk, hydration needs of residents." -"11. Use of mechanical lift(s) training to be conducted on an annual or PRN schedule to include sit-to stand and hoyer lifts. Personnel whom the facility determines will have no contact with patients or residents are exempt form training required by subdivisions (5), (9),(10), and (11) of this section." *Abuse, neglect, and misappropriation of resident property and funds were not included in their policy.	S 206		