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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. BUILDING _____ B. WING _____	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN HOME	1001 S EGAN AVE MADISON, SD 57042

(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: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/24/21 through 8/26/21. Bethel Lutheran Home was found not in compliance with the following requirements: F603, F604, F684, F692, F697, F700, F758, F801, and F880.	F 000	STATEMENT OF COMPLAINCE: The following represents the plan of correction for alleged deficiencies cited during the survey that was conducted from08/24/2021 through 08/26/2021. Please accept this plan of correction as Bethel Lutheran Home's Credible Allegation of Compliance with the completion date of 09/19/2021. The completion and execution of this plan of correction does not constitutean admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith as Bethel Lutheran Home's commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
F 603 SS=D	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Surveyor: 44928 Based on observation, interview, record review, and policy review the provider failed to ensure one of one sampled resident (14) had not been secluded in quarantine unnecessarily. Findings include: 1. Observation and interview on 8/24/21 at 9:34 a.m. with resident 14 revealed she: *Was seated in her recliner reading a book.	F 603	Residents residing in the facility have the potential to be affected in a similar manner. The Infection Control Nurse and DON will reeducate all staff responsible for admissions and updating care plans to ensure residents are free from involunatry seclusion. Will review situation with resident 14 and the resident's responsible person to ensure her choice to remain in room and socialilaztion needs are being met. All new admissions will be auditied to ensure they are not in quarantine longer than 14 days regardless of vaccination status. All residents admitted within the last 90 days will be audited to ensure they are not in quarantine longer than 14 days regardless of vaccination status. Director or designee will complete audits on all residents to ensure they are free from involuntary seclusion weekly for 4 weeks and monthly for 3 months. Director of Nursing will bring results of the audits to the monthly QAPI meeting for further review or recommendation.	09/17/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: CR Johnson
TITLE: Administrator
(X6) DATE: 09/15/2021

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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*Had been admitted on 6/3/21.
*Was in quarantine since her admission.
*Thought she had to remain in quarantine until she was fully vaccinated for COVID-19.
*Had been out of her room for bathing, therapy, and went to the beauty shop when no other residents were in those areas.
*Had received her vaccine for COVID-19 on 8/15/21 and remained in quarantine.
*Stated, "I don't have a problem with it [being quarantined], I like being in my own room. I like to read, watch TV, and my kids come to visit all the time."

Review of residents 14's progress notes revealed:
*On 6/15/21 the plan was for her to receive the COVID-19 vaccination 90 days after having a positive COVID-19 test.
-She had tested positive for COVID-19 prior to being admitted.
*She had wanted to come out of her room to attend bingo and church activities.
-She had understood she would need to wear a mask, social distance and would not be able to attend meals in the dining room until she was full vaccinated.
*She had done self-directed activities in her room.

Review of residents 14's current care plan revealed she:
*Ate her meals in her room.
*Had received therapy in her room or alone in the therapy room at the end of the day.

Interview on 8/26/21 at 8:25 a.m. with licensed social worker B regarding resident 14's quarantine revealed:
*She had been in quarantine since 6/3/21

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because she was not vaccinated for COVID-19.
*She was a very private person and she had been content staying in her room.
*Residents who were fully vaccinated, on admission, did not need to be in quarantine.

Interview on 8/26/21 at 9:52 a.m. with resident 14's son regarding her being quarantined to her room revealed he believed:
*Unvaccinated residents had to be quarantined to their room.
*It was the "rules of the home".
*She would be removed from quarantine after being vaccinated for COVID-19.
*She had lived in an apartment, was a very private person, and did not generally socialize with others.

Interview on 8/26/21 at 10:53 a.m. with the director of nursing A regarding resident 14's quarantine revealed:
*The provider would have ended her quarantine if all the others residents were notified of an unvaccinated resident in the facility.
-All residents would have had the option to wear a mask in social areas.
-All resident had not been notified of an unvaccinated resident and their option of choosing to wear a mask or not.

Surveyor: 43844
Review of the provider's 4/27/21 updated admission policy during COVID-19 revealed in part:
*New residents who are not fully vaccinated:
-"Will be quarantined to their rooms for a period 14 days or longer should transmission based policies indicate.

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F 603	Continued From page 3 -Will be restricted from attend [attending] group activities. -Will be restricted from communal dining." Review of the provider's 6/16/20 updated COVID-19 policy and procedure revealed in part: "New admissions will remain in isolation for 14 days with the door closed."	F 603		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 604	Residents residing in the facility have the potential to be affected in a similar manner. Assessments for physical restraints were completed for residents 12 and 28. Care plans were updated to ensure that current interventions are approriate and no physical restraints are present. The Director of Nursing will redducate all staff about phyical restraints and all staff responsible for completing assessments and updating care plans. Director of Nursing or designee will audit care plans to ensure assessments for physical restraints are updated weekly for 4 weeks then monthly for 3 months. Director of Nursing will bring results of audits to the monthly QAPI meeting for further review or recommendation.	09/17/2021

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alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.
This REQUIREMENT is not met as evidenced by:
Surveyor: 44928
Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (12 and 28) had been assessed for potential restrictive interventions.
*Resident 28 wears a potential lap restraint.
*Resident 12's bed was not accessible to her (too high for her to enter). Findings include:
1. Observation and interview on 8/24/21 at 11:45 a.m. of resident 28 in the dining room revealed he had:
*Been sitting straight up in his wheel chair.
*A green cloth belt, approximately 4 inches wide, wrapped around his wheelchair and across his waist connected with Velcro.
-Stated the belt was, "to help me sit up straight".

Review of resident 28's medical record regarding the belt revealed:
*He had diagnosis of:
-Dementia with lewy bodies.
-Hemiplegia, unspecified affecting right dominant side.
-Parkinson's disease.
*He had been admitted on 5/18/20.
*His care plan did not address the use of the belt.
*He had received a wedge cushion on 7/1/20 to assist in positioning.
*There were no assessments completed to determine if the belt would have been a restraint.
*There had not been a physician's order for the use of the belt.

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Interview on 8/26/21 at 8:28 a.m. with licensed social worker B regarding resident 28's belt revealed his wife had made the belt for him because she did not like the positioning wedge he had been using.

Interview on 8/26/21 at 8:47 a.m. with restorative nurse/assistant director of nursing L regarding resident 28's belt revealed:
*She had been aware he was using the belt.
*She had not completed an assessment to determine if it was a restraint.

Interview on 8/26/21 at 10:58 a.m. with director of nursing A regarding resident 28's belt revealed:
*She had been aware he was using the belt.
*Her expectation would have been for the restorative nurse to complete a restraint assessment before the use of the belt was started.

Surveyor: 43844
2. Observation on 8/24/21 at 4:24 p.m. of resident 12's room revealed:
*The bed had been in the high position.
*There had been a sign above the bed that read, "Please leave bed in highest position when resident is not in bed."

Review of resident 12's medical diagnosis revealed she had:
*Hemiplegia and hemiparesis affecting left non-dominant side.
*Mental disorders.
*Speech disturbances.

Review of resident 12's 6/8/21 brief interview of mental status revealed her cognition was severely

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impaired.

Interview on 8/26/21 at 11:04 a.m. with DON A revealed:
*The bed was kept in the highest position, "because if we put her bed in a low position she will crawl into bed and that is how she falls, so we put her bed in a high position so she can't crawl into bed and fall."
*She often attempted to transfer herself into bed after supper.
*DON A felt putting the bed in the high position had not prevented her from falling.
*DON A felt putting the bed in the low position had not prevented her from falling.
*DON A agreed putting the bed in the high position restricted her ability to get into the bed and that it would have been a restrictive intervention.
*DON A stated, "We should find a new intervention."

Review of resident 12's fall investigation forms record revealed:
*She had used a wheelchair to move around the facility.
*She had fallen on:
-5/22/21 at 6:30 p.m. while standing in the bathroom with staff assistance and lowered to the floor by staff when she had started to fall.
-7/9/21 at 6:20 p.m. while trying to get into her bed after supper.
--She had not waited for the staff to assist her.
--The intervention was to raise the bed to a high position to keep her from attempting to transfer herself into the bed.
-8/3/21 at 6:35 p.m. while trying to get into bed after supper.
--Her bed had been in the lowest position.

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Review of resident 12's fall care plan revealed:
*She had been at high risk for falls.
*The following interventions:
-5/21/19 to raise the bed to discourage self transfers.
-5/28/19 to always have the bed in the lowest position and do hourly rounding.
-1/14/21 to assist the resident with evening cares and help her into bed after supper due to high fall risk.
-2/11/2021 Staff had been reminded to make sure bed breaks are always on.
-7/15/2021 The bed was to be left in the high position when the resident was not in bed to prevent
self-transferring.
-8/4/2021 A sign was hung in the room to remind staff to keep the bed in high position when the resident is not in it.

Review of resident 12's medical record revealed:
*No assessments had been completed to determine if raising the bed to the high position to prevent her from self-transferring had been a restraint.
*There had not been a physician order for a restraint.

3. Review of the provider's 2/11/19 restraint policy revealed in part:
*"This facility will not impose physical restraints for the purposes of discipline or convenience. On rare occasions, it may be medically necessary to consider the use of a physical restraint and/or psychotropic medications."
-"1. Prior to the initiation of a physical restraint or psychotropic medication(s), clinicians will thoroughly assess the resident's mental/cognitive,

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F 604	Continued From page 8 behavior and physical status. This assessment will address other interventions that may be symptoms or the cause of the situation (e.g., identification of an infections process or delirium, presence of pain). Documentation of assessment/evaluation and symptoms exhibited will be recorded in the resident's medical record. Clinicians will consult with the attending physician, relaying assessment and observations. Alternatives, less restrictive measures, to the use of a physical or chemical restraint must be initiated and recorded, including effectiveness of any/all alternatives employed. Clinicians and attending physician must determine that a physical restraint is a measure of last resort to protect the safety of the resident or others. If there is no alternative to the use of a restraint, a physician's order is necessary for the initiation of any restraint or psychotropic medication. That order will include the physician's diagnosis and include the medical symptoms prompting the need for such restraint. It will also include the expected duration of the restraint."	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		

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F 684	Continued From page 9 by: Surveyor: 43844 Based on observation, interview, and record review, the provider failed to ensure one of one sampled resident (12) had been evaluated to ensure she had the necessary support for proper positioning. 1. Observation on 8/24/21 at 12:17 p.m. of resident 12 revealed she: *Had been sitting in her wheelchair. *Had been using her right foot to move her wheelchair down the hallway. *Could not use her left foot. -There were no supporting foot pedals on her wheelchair for her left foot. -Her left foot had been slightly under her wheelchair and had bounced off the floor with each forward movement of the wheelchair made by her right foot. Review of resident 12's medical record revealed: *She had been admitted on 12/14/18. *Her diagnosis had included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, another other cerebrovascular disease, and another diagnosis. *Her care plan had included a focus on her inability to complete self-care due to her confusion and a stroke. -The care plan did not have any interventions for the proper positioning of her left foot and her inability to properly position it herself. Interview with director of nursing (DON) A regarding resident 12's left foot positioning revealed: *Her left foot 'drags'. *She could move her left foot 'a little'	F 684	Residents residing in the facility have the potential to be affected in a similar manner. Resident 12 was screened by Occupational Therapy for positioning of left foot. The Assistant Director of Nursing completed a safe handling and movement assessment of Resident 12. The left footrest was applied to resident 12's wheelchair. The Director of Nursing will reeducate staff responsible for completing safe handling and movement assessments and update care plans. Occupational Therapy or Physical Therapy will complete screens quarterly or when a sigfiigant change occurs to determine need for interventions. Interventions will be made and care plans will then be updated. The Director of Nursing or designee will audit therapy screens and safe handling and movement assessments weekly for 4 weeks and monthly for 3 months. The Director of Nursing will bring results of audit to the monthly QAPI meeting for further review and recommendation. The Director of Nursing or designee will audit care plans weekly for 4 weeks and monthly for three months. The Director of bring the results of the audit to the monthly QAPI meeting for further review and recommendation.	09/17/2021

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F 684	Continued From page 10 *She used the right foot to propel herself in the wheelchair. *She had not been assessed by the physical therapy or occupational therapy staff for positioning of her left foot. Surveyor: 44928 Interview on 8/26/21 at 8:51 a.m. with restorative nurse/assistant director of nursing (RA/ADON) L regarding resident 12's dragging her left foot revealed: *RA/ADON L completed quarterly safe resident handling and movement assessments. -RA/ADON L had not assessed her left foot on these assessments since her admission. *They had offered her a foot pedal for her wheelchair in 12/2018, and she had refused it. -They had not offered her a foot pedal since that time.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692	Residents residing in the facility have the potential to be affected in a similar manner. Resident 20 signifigant weight loss was reviewed by the Registered Dietician (RD). Care plan was updated. RD and Director of Nursing (DON) reviewed and updated the Signifigant Weight Loss Policy. Staff re-educated on Signifigant Weight Loss Policy. DON, RD, Dietary Manager (DM), and care team will review signifigant weight loss report weekly during the Skin Hydration meeting. Potential interventions for residents with signifigant weight loss are discussed. The RD completes nutrtion assessments on residents related to weight loss and identifies interventions. The RD will update care plans. The DON, DM or RD will audit the signifigant weight loss report weekly for 4 weeks then monthly for 3 months. The DM or RD will bring the results of those audits to the monthly QAPI meeting for further review and recommendation.The RD or DM will audit nutrition assessments related to weight loss weekly for 4 weeks then monthly for 3 months. The DM or RD will bring results of those audits to the monthly QAPI meeting for further review and recommendation.	09/17/2021

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F 692	Continued From page 11 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Surveyor: 44928 Based on interview, record review, and policy review, the provider failed to ensure one of one resident (20) with significant weight loss had been assessed by a registered dietitian (RD) G. Findings include: 1. Review of resident 20's medical record regarding weight loss revealed: *She had a significant weight loss of 13.17% from 2/26/21 through 8/23/21. *RD G had completed an annual nutrition assessment on 3/18/21, documenting: -Her weight had trended downward over the past year, and more significantly over the past few months. -She had refused to eat at times, and was too sleepy to eat at other times. -The intervention had been to continue with a regular diet, and to offer snacks or supplements when her meal intake was less than 50%. --This intervention had not been included in her care plan. --There had been no new interventions for weight loss since 12/31/18. *RD G had not made weekly, monthly, or quarterly notes. Interview on 8/25/21 at 5:27 p.m. with RD G	F 692		

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regarding resident 20's weight loss revealed:
*The provider had a skin and hydration team that met usually on Thursdays.
*Weight loss of residents had been discussed at these meetings and new interventions were implemented for those residents who had been losing weight.
*The social worker would write progress notes in the residents' medical record regarding these meetings.
*She had completed annual nutrition assessments for all residents.
*She agreed she had been aware of the weight loss, should have addressed the weight loss, and should have documented any interventions for the weight loss of resident 20.

Interview and policy review on 8/26/21 at 1:53 p.m. with the director of nursing B regarding resident 20's significant weight loss revealed:
-Her weight loss had been reviewed at the weekly hydration team meetings, and new interventions made if the team decided they were necessary.
-She no longer took attendance at these meetings, so she did not know if RD G attended each meeting.
--She stated RD G had "typically" attended those meetings.
-RD G's hours in the facility had been reduced from one day per week to one day per month, beginning the spring of 2021.
-She reviewed the provider's significant weight loss policy with the surveyor and agreed RD G had not been following that policy.

Review of the provider's 2/1/18 significant weight loss policy in part revealed:
*"Policy: All individuals with weight changes will be identified so that appropriate interventions can

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F 692	Continued From page 13 be implemented." -"The following guidelines will be reviewed when evaluating weight changes: -30 days +/- 5%; 90 days +/- 7.5% 180 days +/- 10%. [+/- meaning weight loss of greater than or less than.] --After the weight report is reviewed, the RD will evaluate the change of those residents. The time frame for evaluation is within one week of the weight having been taken. --The RD will document in the medical record probable cause, pertinent information, and plan of action. The care plan will be updated. The RD will determine whether the resident need[s] to be followed as a high-risk resident."	F 692		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Surveyor: 45095 Based on observation, interview, record review and policy review, the provider failed to ensure adequate pain control was monitored, reviewed, and appropriate interventions were implemented, including physician notification for one of one sampled resident (2) who had complaints of increased pain. Findings include: 1. Observation and interview on 8/24/21 at 4:31	F 697	Residents residing in the facility have the potential to be affected in a similar manner. Pain assessment completed on Resident 2. Physician perscribed prn med for pain. Care plan was updated. DON re-educate all staff on Pain Assessment and Management Policy. Nursing staff will assess resident's pain during each shift and document the resident's reported pain level. Nursing staff will report a signifigant change in the resident's level of pain or prolonged, unrelieved pain to the physician. DON or MDS Coordinator will update the care plan. DON will audit pain assessments weekly for 4 weeks then monthly for 3 months. DON or designee will bring the results of those audits to the monthly QAPI meeting for further review and recommendation. DON will audit care plain for pain management weekly for 4 weeks then monthly for 3 month. DON or designee will bring the results of those audits to the monthly QAPI meeting for further review and recommendation.	09/17/2021

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p.m. with resident 2 revealed she:
*Was alert and able to answer questions appropriately.
*Had reported pain in her left knee related to an incident of being repositioned by night staff during which her left knee was twisted.
-She could not recall the specific date this incident occurred.
*Stated she felt she should have gone to the doctor.
*Had pain in her left knee and verbalized she hoped the knee pain would get better.

Interview on 8/25/21 at 5:30 p.m. with certified nursing assistant (CNA) D regarding resident 2 revealed:
*She was dependent on staff for activities of daily living, but she could maneuver her mechanical wheelchair independently.
*She recently complained of left knee pain with transfers and repositioning that lasted for one to two weeks.
*CNA D had reported her pain to the charge nurse every day she worked in the last one to two weeks.
*CNA D had noticed increased swelling in resident 2's left knee for two days during the last one to two weeks and reported swelling to the charge nurse.
*Staff would support and keep resident's left knee level during transfers due to resident crying out in pain.
*She was transferred without pain complaints on 8/25/21.

Interview on 8/26/21 at 8:14 a.m. with CNA E regarding resident 2 revealed:
*She required extensive assistance from two staff for activities of daily living and transfers.

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*CNA E stated she had "pretty bad" increased pain and swelling in the left knee for the past two weeks.
*CNA E had informed the charge nurse of residents increased left knee pain and the charge nurse had given her pain medications "which seems to take the edge off."
*Staff must hold the resident's legs up and keep them even and level when transferring or moving due to the left knee pain.
*Staff used a pillow to prop her left knee up which helped alleviate her pain.
*CNA E reported resident 2's pain had improved the morning of 8/26/21.

Interview on 8/26/21 at 10:40 a.m. with registered nurse (RN) C regarding resident 2 revealed:
*She received acetaminophen three times a day for pain.
*She had no other pain medication ordered.
*She had a history of chronic lower extremity swelling and pain.
*RN C denied any recent changes or CNA reports regarding resident changes in pain or swelling.
*She had recently experienced increased hallucinations and was started on Ativan.
*Ativan seemed to improve resident pain and hallucinations.

Interview on 8/26/21 at 2:42 p.m. with the director of nursing (DON) A regarding resident 2 revealed:
*DON A stated resident 2 had a history of knee pain and a left knee stress fracture.
*DON A described intervention used by staff to hold resident's knees level with repositioning, stated otherwise resident cried out in pain or anticipation and fear of pain.
*DON A stated she was aware resident had increased complaints of left knee pain for a few

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days but thought her pain had "gotten better."
*DON A stated a nurse had asked resident 2 if she wanted to go to the doctor which resident answered with a "no."
*DON A stated resident does not like to go to the doctor.
*DON A reported her expectation was that; the resident's refusal to go to the doctor would have been documented, effectiveness of acetaminophen documented, non-medical pain interventions offered and documented, and that the physician would have been notified of increased pain complaints with physician follow up documented.
*The care plan was reviewed with DON A and she acknowledged the care plan did not have a history of knee pain or interventions for left knee pain.

Review of resident 2's medical record revealed:
*A diagnoses history of osteoporosis and stress fracture of the left knee in 2015.
*The physician had not been notified of the resident's complaints of increased pain in the left knee.
*The care plan listed pain with related diagnoses of osteoporosis and headaches.
*The only intervention listed for pain was acetaminophen which had been on the care plan since 12/16/19.
*Care plan did not include left knee pain.
*RN (I) nurse progress note dated 8/11/21: "CNA reports [resident 2's name] c/o [complained of] increased left knee pain with movement, repositioning and transfer. No redness or warmth to skin increased edema left knee. Will continue to monitor for changes. Acetaminophen given."
*RN (J) nurse progress note dated 8/12/21: "Acetaminophen 2 tabs [tablets] tid [three times

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F 697	Continued From page 17 daily] pain. Resident screaming in pain states left knee is in severe pain. No changes in edema from normal, no redness or bruising." *No documentation of the effectiveness of scheduled acetaminophen administered on 8/11/21 or 8/12/21. Review of the provider's revised November 2018 Pain Assessment and Management policy revealed: *"General Guidelines:" -"5. Conduct a comprehensive pain assessment, including the resident's acceptable level of pain upon admission to facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain." *"Documentation: -1. Document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program." *"Reporting: -1. Report the following information to the physician or practitioner: --a. significant changes in the level of the resident's pain." --"c. Prolonged, unrelieved pain despite care plan interventions."	F 697		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed	F 700		

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F 700	Continued From page 18 rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 16385 Based on observation, record review, interview, and policy review, the provider failed to ensure six of six sampled residents (2, 3, 4, 6, 39, and 50) who had quarter length side rails on their beds had received education on the risks of side rails and had signed consents for use. Findings include: 1. Observation on 8/24/21 at 4:31 p.m. revealed two quarter side rails in the up position on resident 50's bed. The resident was not in bed at this time. Review of resident 50's medical record revealed: *A 2/24/21 physician's order for half side rails. *Quarterly bed rail assessments had been completed.	F 700	Residents residing in the facility have the potential to be affected in a similar manner. Residents 2, 3, 4, 6, 39, and 50 or their authorized responsible represenative were educated on risks of side rails. The LSW contacted the resident's responsible representative to educate risk of side rails. A copy of the bed rail policy and consent form was given to the resident's representative. The DON will re-educate all staff on bed rail policy. The DON or ADON will complete audit weekly for 4 weeks then monthly for 3 months to ensure all residents with bed rails or thier responsible representative have received education on risks of bed rails and signed consent forms. The DON or designee will bring the results of audits to the monthly QAPI meeting for further review or recommendation.	09/17/2021

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Surveyor: 45095
2. Observation and interview on 8/24/21 at 4:31 p.m. with resident 2 revealed:
* One quarter side rail in the up position on the left side of the bed.
* Resident 2 was in her mechanical wheelchair during the interview.
* Resident denied using side rail.
* Resident stated she is dependent on staff for all transfers and personal care.

Review of resident 2's medical record revealed:
* A physician order for half-side rails.
* Quarterly side rail assessments had been completed.

3. Observation and interview on 8/24/21 at 3:37 p.m. with resident 6 revealed:
* One quarter side rail in the up position on the right side of bed
* Resident 6 was lying in bed during the interview.
* Resident stated she uses the side rail to assist with positioning and getting in and off the bed.
* Resident was able to get in and out of bed independently.

Review of resident 6's medical record revealed:
* A physician order for half-side rails.
* Quarterly side rail assessments had been completed.

Surveyor: 41895
4. Observation and interview on 8/24/21 at 2:33 p.m. of resident 4 in bed, positioned on her right side revealed she:
*Had a side rail on the right side of the bed.
*Used the side rail to assist with positioning in the bed.

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Review of resident 4's medical record revealed:
*Side rail assessments had been completed on 3/6/21, 6/5/21, and 8/17/21.
*A 11/4/2016 physician order for half side rails.

5. Observation on 8/24/21 at 3:20 p.m. of resident 3 revealed she was asleep in bed, positioned on her right side, with a half side rail to the left side of the bed in the up position.

Review of resident 3's medical record revealed:
*Side rail assessments had been completed on 2/26/21, 5/27/21, 7/2/21, and 8/17/21.
*A 6/5/18 physician order for half side rails.

6. Observation on 8/24/21 at 3:25 p.m. of resident 39 asleep in bed, positioned on his right side, with a half side rail to the left side of the bed in the up position.

Review of resident 39's medical record revealed:
*Side rail assessments had been completed on 4/15/21 and on 7/13/21.
*A 4/8/21 physician order for half side rails.

7. None of the identified residents had received education about the risks of side rails or had signed consent for the use of the side rails.

8. Interview on 8/24/21 at 4:15 p.m. with director of nursing (DON) A and assistant director of nursing (ADON) L revealed:
*Side rail assessments are done quarterly and as needed.
*Physician order is required for a resident to have a side rail on their beds.
*The provider had not educated residents or resident representatives on the benefits or risks

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F 700	Continued From page 21 of side rail use. *Do not obtain a consent for the side rails. 9. Review of the provider's revised August 2021 Side Rail Use policy revealed it had not addressed: *Educating on the risks or benefits of side rail use. *If consent was required before side rail use.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	Residents residing in the facility have the potential to be affected in a similar manner. An physician order for a gradual dose reduction (GDR) for resident 28 was received on 08/27/2021. DON will re-educate all staff responsible for processing and docmenting pharmacy recommendations to ensure GDR are addressed. DON will review all completed pharmacy recommendations upon return from the doctor. After reviewing, the DON will sign and date ithe pharmacy review and place in residents chart. Care plans will be updated with new recommendations. DON will audit pharmacy recommendations and care plans weekly for 4 weeks then monthly for 3 months. DON will bring results of the audit to the monthly QAPI meeting for further review and recommendation.	09/17/2021

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F 758	Continued From page 22 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, record review, and policy review, the provider failed to ensure one of five sampled residents (28) receiving psychotropic medications had: *Received a gradual dose reduction (GDR) within the required time frame for the prescribed psychotropic medications. *Timely response and documentation from the physician for the pharmacist recommendations that include documentation to support why a GDR was clinically contraindicated. Findings include: 1. Review of resident 28's medical record revealed: *He had been admitted on 5/18/20 with diagnoses of major depressive disorder, single	F 758		

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episode; insomnia; and numerous other diagnoses.
*His 6/20 patient health questionnaire (PHQ-9), which is a questionnaire for depression, revealed he had no signs and symptoms of depression.
*There was no other documentation that he had been experiencing depression.

Review of resident 28's current physician's orders revealed he had been prescribed three psychotropic medications:
-Abilify 5 milligram (mg) daily for major depressive disorder.
-Vortioxetine 10 mg daily for major depressive disorder.
-Buspirone 15 mg twice daily for anxiety.

Review of resident 28's May 2021 through August 2021 monthly consulting pharmacist N reviews revealed:
*On the 5/12/21 review, consulting pharmacist N had indicated resident 28 had been receiving several psychotropic medications that included:
-Abilify 5 mg daily prescribed since 5/18/20.
-Buspirone 15 mg twice daily prescribed since 5/18/20.
-Vortioxetine 10 mg daily prescribed since on 5/18/20.
-His recommendation had been, "Is there any potential to try a slight reduction on one of the above mentioned medications? If the medications need to continue unchanged, please list clinical reasons to show that a reduction is clinically contraindicated."
-His primary medical provider had declined a dosage reduction and documented on 5/19/21, "If he begins to show signs of less depression, a dose change can be entertained. His psych provider started him on these."

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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*There had been no pharmacy recommendations for June and July.
*The 8/9/21 pharmacy recommendation had been to:
-Reduce the Abilify 2.5 mg daily for 14 days, then;
-Reduce the Abilify 2.5 mg to every other day for 14 days, then;
-To stop the Abilify.
--The physician had not responded to the recommendations by the end of the survey on 8/26/21.
--His physician's order had been for Abilify 5 mg daily.

Interview on 8/26/21 at 8:45 a.m. with licensed social worker B regarding resident 28's psychotropic medication revealed:
*He had refused to be evaluated by a psychiatrist when he was admitted on 5/18/20.
*He had not been offered psychiatry services since.

Interview on 8/26/21 at 9:54 a.m. with director of nursing A regarding resident 28's psychotropic medication revealed:
-Progress notes would have shown the signs and symptoms of depression if he had them.
-He had not seen psychiatry.
-She was unsure why his primary physician referred to 'his psych provider started him on these."

Review of the provider's 3/12/20 gradual dose reduction policy revealed in part:
*"1. During the monthly drug regimen review [MRR] the pharmacist evaluates resident-related information, including the resident's medical record for: dose, duration, continued need, and emergence of adverse consequences for all

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	435076	A. BUILDING _____ B. WING _____	08/26/2021

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BETHEL LUTHERAN HOME	1001 S EGAN AVE MADISON, SD 57042

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medications. The resident's medical record will reflect the monthly drug regimen review, results and any/all correspondence as defined in the drug regimen review policy.

2. When evaluating the resident's progress, the attending physician reviews the total plan of care, orders, the resident's response to medication(s), and determines whether to continue, modify or stop a medication and evaluate mood, function, behavior and other domains that may be affected by medications. The resident's medical record will reflect such evaluation in the physician's progress notes and orders, as appropriate.

3. Within the first year in which a resident is admitted on an antipsychotic medication or after the facility has initiated an antipsychotic medication, a gradual dose reduction (GDR) must be attempted in two (2) separate quarters, with at least one (1) month between the attempts, unless clinically contraindicated.

4. A GDR may be considered contraindicated if:
i. The resident's target symptoms returned or worsened after the most recent attempt at a GDR after admission not the facility or initiation of an antipsychotic medication and,
ii. The physician has documented the clinical rationale for why any additional attempt at a dose reduction at that time would be likely to impair the resident's function, increase distressed behavior, cause psychiatric instability or exacerbate an underlying medical or psychiatric disorder."

"6. The resident's medical record will reflect all attempts at gradual dose reduction during the resident's stay in the facility

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F 758	Continued From page 26 7. The resident's medical record will include documentation of all behavior issues as well as the effectiveness of interventions."	F 758		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he	F 801	Residents residing in the facility have the potential to be affected in a similar manner. Staff member identified as DM F was enrolled in Certified Dietary Manager course by 09/14/2021. The Administrator will ensure that a Certified Dietary Manager or a qualified nutrtion professional is in the facility 5 days per week. The Regional Director from Healthcare Services Group will deliver a schedule for Certified Dietary Manager to the Administrator each week to ensure appropriate coverage. This will be posted in the Dietary Manager office and in the kitchen. The estimated completion date for the CDM course is 6 to 9 months. The Administrator will receive updates on course progression until certification has been obtained. The Administrator will audit the Certified Dietary Manager schedule weekly for 4 weeks and monthly for 3 months. The Administrator will bring the results of the audit to the monthly QAPI meeting for further review and recommendation. The Administrator will audit progression of CDM course for employee DM F weekly for 4 weeks and monthly until employee DM F has achieved Certified Dietary Manager certification. The Administrator will bring the resultsof the audit to the monthly QAPI meeting for further review and recommendation.	09/17/2021

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or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional.
This REQUIREMENT is not met as evidenced by:

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F 801	Continued From page 28 Surveyor: 43021 Based on interviews and job description review, the provider did not employ a full-time qualified dietitian to serve as the director of food and nutrition services (DFNS) and failed to ensure the dietary manager (DM) met the requirements to serve as the DFNS. Findings include: 1. Interview on 8/24/21 at 9:25 a.m. with the DM F revealed: *She had started her position as DM on 8/9/21. *She was not a certified dietary manager (CDM). *She was in the process of registering for the CDM course. Interview on 8/25/21 at 2:42 p.m. with registered dietitian G revealed: *She was not full-time. *She was typically scheduled 2 days a month but did try to get to the facility every week. Interview on 8/26/21 at 9:56 a.m. with senior district manager H for contracted dietary services revealed: *the provider had contracted their dietary services. *DM's job description was currently identified as dining services manager in training (MIT). Review of the contracted dietary services's dining services MIT job description revealed the qualifications included "CDM participant or certification preferred."	F 801		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		

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infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual 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

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F 880	Continued From page 30 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and 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: 41895 Based on observation, interview, and policy review, the provider failed to ensure proper hand hygiene practices were followed by one of one registered nurse (RN) (M) during care for one of one sampled resident (156). Findings include: 1. Observation on 8/24/21 from 11:17 a.m. through 11:32 a.m. of RN M while providing care for resident 156 revealed she: *Returned to and left resident 156's room three times: -To check on him. -To get an oxygen concentrator	F 880	The administrator and Director of Nursing in consultation with the medical director and infection control nurse will review, revise, create as necessary policies and procedures about: Appropriate hand hygiene and procedural technique. Procedural technique during provision of nebulizer treaments. Applying oxygen. Entering and exiting a room. Necessary infection control and prevention plan that includes compliance. RN M provided above care and services to resident 156 on 08/26/2021 at 2:11pm will be educated /re-educated by Director of Nursing by 09/17/2021. ALL residents have the potential to be affected if staff do not adhere to: Appropriate hand hygiene and procedural technique during provision of nebulizer treatments, applying oxygen, and entering and exiting a resident's room. ALL staff completeing the care and/or assigned tasks have the potential to be affected. Policy education /re-education about roles and responsibilities for the above assigned task(s) will be provided by 09/17/21. The Director of Nursing, Assistant DON, and the Infection Control Nurse will hold an All-Staff in-service to review the policy on hand hygiene, re-educate compentencies for hand hygiene and technique and view "Create a Culture of Safety with Partnering to Heal." Root Cause Analysis conducted answered the 5 Whys: 1. Resident had signifigant change in health status. 2. Staff realized the signifigant change in health status and the urgency to intervene. 3. Urgency to obtain appropriate equipment and intervene. 4. Urgency to notify family, physician, and make arrangements to transfer the resident. 5.The resident had a signifigant decline in mentation, ADL's, and oxygenation. Required transport to the ER with subsequent admission to the hospital followed by the resident passing away hours later. Administrator, DON, infection control nurse and the medical director will ensure ALL facility staff responsible for assigned task(s) have received education/training with demonstrated compentency.	

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F 880	Continued From page 31 -To remove his nebulizer mask and shut off the machine. -To get oxygen tubing, assembled the oxygen concentrator, and put oxygen on him. *It was only when she left the room the last time, she performed hand hygiene. Interview on 8/24/21 at 2:11 p.m. with RN M regarding the above observation revealed she had agreed she should have performed hand hygiene each time she entered and exited a resident's room. Interview on 8/26/21 at 2:38 p.m. with DON A revealed she: *Had spoken with RN M on the phone regarding the above observation and had told her she was to sanitize her hands each time she entered and exited a resident's room. -RN M had told her she knew she should have used the alcohol-based hand sanitizer each time she entered and exited a resident's room. *All staff had education and competencies on hand hygiene. Review of the provider's revised October 2018 Handwashing/Hand Hygiene policy revealed: *"Use an alcohol-based hand rub containing at least 60% alcohol, or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" -"b. Before and after direct contact with residents." -"c. Before preparing or handling medications." -"l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident."	F 880	continued from page 31 Tammy Struwe, Infection Control Nurse contacted Lori Hintz, QIN on 09/10/2021 at 0750 via phone to discuss F880 tag and the situation of events. The "5 whys" were discussed and acknowleged that the urgency of the situation was one of the precipitating factors. We identified opportunities existed for proper hand hygiene and RN M recognized this immediately after the event. Hand sanitizer stations are located by the door in each resident room, random locations in each hallway, and in common areas throughout the building. The hand sanitizer station in the resident room was functioning properly upon inspection. The Infection Control RN and DON will provide re-education to ALL staff, to include compentencies. The Infection Control RN will audit hand hygiene technique and practices throughout the facility on all shifts 4 days per week for 4 weeks and twice monthly for 2 months then monthly there after. The Infection Control RN will bring audits to the monthly QAPI for review and recommendation for sustained compliance.	09/17/2021

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

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E 000	Initial Comments Surveyor: 16385 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 8/24/21 through 8/26/21. Bethel Lutheran Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: CR Johnson
TITLE: Administrator
(X6) DATE: 09/15/2021

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/24/21. Bethel Lutheran Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K300 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	STATEMENT OF COMPLAINCE The following represents the plan of correction for the alleged deficiencies cited during the survey that was conducted from 08/24/2021 through 08/26/2021. Please accept this plan of correction as Bethel Lutheran Home's Credible Allegation of Complaince with the completion date of 09/19/2021. The completion and execution of this plan of correction does not constitute an admission of guilt or wrong doing on the part of the living center. This plan of correction is completed in good faith as Bethel Lutheran Home's commitment to quality outcomes for the residents. In additon, this plan of correction is completed as it is required by law.	
K 300 SS=D	Protection - Other CFR(s): NFPA 101 Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain the fire-resistive rating for one of one randomly observed two-hour building separation wall (between the nursing home building and assisted living center). Findings include:	K 300	Residents residing in the facility have the potential to be affected in the similar manner. The latch of the west door leaf of the ninety-minute, cross-cooridor doors in the two-hour, fire-rated wall of the separation wall between the nursing home and the assisted living will be re-calibrated and all moving parts will be lubricated by 09/17/21. All doors requiring nintey minute fire rating will be checked for proper operation weekly for 4 weeks then monthly for 3 months and annotated on logs. All doors requiring the ninety-minute fire rating will be addedd to the preventive maintenance in TELS system and checked monthly to ensure proper operation. Maintenance Supervisor or designee will audit door logs to ensure the above policy is followed weekly for 4 weeks and monthly then 3 months and will bring results of audits to the monthly QAPI meeting for further review and recommendation.	09/17/2021

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

TITLE
Administrator

(X6) DATE
09/15/2021

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

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K 300	Continued From page 1 1. Observation and testing on 8/24/21 at 2:18 p.m. revealed the west leaf of the ninety-minute, cross-corridor doors in the two-hour, fire-rated separation wall nursing home building and the assisted living center addition was not latching. That door leaf must latch to maintain the two-hour fire-rating of the wall assembly. Interview with the maintenance supervisor at the time of the observation confirmed the door was not latching. He stated he was unaware the condition existed. The deficiency could affect 100% of the occupants of the smoke compartments on either side of the fire barrier.	K 300		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		

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BETHEL LUTHERAN HOME	**1001 S EGAN AVE** **MADISON, SD 57042**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 2 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain two separate hazardous areas (boiler room and food storage/housekeeping) as required. Findings include: 1. Observation and testing on 8/24/21 at 10:59 a.m. revealed the fire-rated east entrance door to the boiler room was equipped with a closer but would not latch into the frame under the power of the closer. That room is considered a hazardous area and that door is required to automatically latch into the door frame. 2. Observation and testing on 8/24/21 at 11:22 a.m. revealed the food storage/housekeeping room was over 100 square feet and contained combustible items. The door from that room to the corridor was held open with a bungee cord. That room is considered a hazardous area and that door is required to automatically latch into the door frame. That bungee cord would interfere with the closing of that door in the event of a fire.	K 321	Residents residng in the facility have the potential to be affected in a similar manner. The closers will be recalibrated and all moving parts will be lubricated. Door sweeps will be repaired by replacing broken screw and re-setting the sweep so it will not catch on the floor mount stop. The door stop was reapired to prevent. the door sweeping from catching on the door stop. Maintenance Supervisor or designee will audit doors with closures weekly for 4 weeks then monthly for 3 months to ensure proper operation. Maintenance supervisor will bring the results of those audits to the monthly QAPI meeting for further review or recommendation. The bungee cord was removed from the food service storage area. Maintenance supervisor will re-educate all staff that automatic doors cannot be propped open and must be allowed to close. Door will be checked weekly for 4 weeks then monthly for three months to ensure the door isn't propped open and allowed to close. A log will be kept to audit that doors have been checked at the prescribed frequency. Maintenance Supervisor or designee will audit door logs weekly for 4 weeks then monthly for 3 months to ensure door isn't propped open. The maintenance supervisor will bring the results of the audit to the monthly QAPI meeting for further review or recommendation.	09/17/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/24/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 3 Interview with the maintenance supervisor at the time of the observations confirmed those findings. Failure to provide separation from hazardous areas as required increases the risk of death or injury due to fire. The deficiencies affected 100% of that smoke compartment.	K 321		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10644	A. BUILDING: _____ B. WING _____	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN HOME	1001 S EGAN AVE MADISON, SD 57042

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/24/21 through 8/26/21 Bethel Lutheran Home was found in compliance.	S 000		

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

CR Johnson

TITLE: Administrator

(X6) DATE: 09/15/2021

STATE FORM 6899 LVK911 If continuation sheet 1 of 1