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 _____	01/26/2023

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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/23/23 through 1/26/23. Bethel Lutheran Home was found not in compliance with the following requirement: F880.	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for alleged deficiencies cited during the survey that was conducted from 1/24/2023 through 1/26/2023. Please accept this plan of correction as Bethel Lutheran Homes Credible Allegation of Compliance with the completion date of 2/28/2023. The completion and execution of this plan of correction does not constitute admission of guilt or wrongdoing on the part of Bethel Lutheran Home. This plan of correction is completed in good faith as Bethel Lutheran Homes commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
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 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	F 880	F880 483.80 RN (WCN) provided care on 1/26/2023 at 0935 to Resident 13. RN (WCN) will be educated/re-educated on Bethel's Wound Care Policy. Wound Care Nurse will attend Wound Care Certification class to obtain formal training as well as formal certification. Once certified the Wound Care Nurse will provide ongoing education to RN staff on Wound Care practice/procedure. ALL residents have the potential to be affected if proper wound care procedures are not followed. Formal training as well as continued education will address this deficiency and provide for proper wound care for ALL Bethel Residents. Root Cause Analysis conducted: 1. Lack of formal Wound Care Training and/or certification. 2. Lack of continued education pertaining to wound care policy/procedure. 3. Lack of training for ALL RN staff pertain to wound care. Administrator, DON, Infection Control Nurse and Medical Director will ensure education/ re-education for ALL Nursing staff as well as education/re-education on Bethel's Wound Care Policy.	2/13/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jermiah J. Schneider | TITLE: CEO | (X6) DATE: 2/14/2023

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 880	Continued From page 1 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 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 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: Based on observation, interview, record review, and policy review, the provider failed to ensure a	F 880	Continued from PG 1. Administrator and DON will ensure Wound Care Certification is attained by RN as well as training program implemented for Nursing staff. Administrator contacted QIA on 10 February 2023 at 0930 via phone to discuss F880 Tag. Email follow-up with QIA on 10 February 2023 at 0951 with additional educational wound care opportunities. The "5" whys were discussed and acknowledged that the lack of formal training and certification were the precipitating factors resulting in the F880 Tag. We identified the Root Cause as well as the means to address the deficiency. Administrator and DON will monitor RN progression on Wound Care Certification Training to ensure completion in a timely manner. DON will monitor ALL Nursing staff education/ re-education on Wound Care Policy to ensure understanding of policy. Wound Care Certification Class as well as Wound Care Policy education/re-education will be monitored via the QAPI committee monthly to ensure continued compliance. ADDENDUM: Infection Preventionist or designee will monitor resident wound care and provide "real-time" education for a period of 90 days to ensure compliance with Bethel Lutheran Home's Wound Care Policy. Infection Preventionist to report monthly progression during QAPI Meetings.	2/14/2023

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F 880	Continued From page 2 dressing change for one of three sampled residents (13) with a pressure ulcer had been: *Completed with appropriate and sanitary technique. *Completed according to the provider's wound care policy: Findings include: 1. Observation on 1/26/23 at 9:35 a.m. of registered nurse (RN)/wound care nurse (WCN) C while completing a dressing change for resident 13's pressure ulcer on her coccyx revealed: *She had completed hand hygiene upon entering the room and went to the closet to obtain the wound care supplies. She realized an item was missing and told the resident, "I'll be right back," and left the room to obtain it. *Came back into the room, performed hand hygiene and put on clean gloves. *With those gloved hands she: -Put the packaged supplies on the bedside table without a barrier. -Opened the bottle of Dakin's 0.25 % solution and poured the solution into a four-ounce plastic cup. -Used the bed's remote to raise the resident's bed. -Loosened the resident's incontinent product and repositioned the resident on her left side to complete the wound care to her coccyx. -Held the incontinent product toward the resident's perineum as she was having bladder spasms with urine leakage around her urinary catheter. She said she often had those during repositioning. -Removed the soiled packing from the resident's pressure ulcer area. *Removed the gloves, performed hand hygiene, and put on new gloves. She then:	F 880		

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F 880	Continued From page 3 -Obtained a 4 x 4 gauze and a bottle of wound cleanser from the closet and laid both items on the bed, without first placing a barrier. -Without wiping the tip of the nozzle with an alcohol pad, she sprayed the wound cleanser on the resident's wound, and used the 4 x 4 gauze to wipe the wound area. -At that time the resident had begun to have a bowel movement. -Wearing the same gloves, she used cleansing wipes to complete perineal care, removed the soiled incontinent product, and placed a clean incontinent product underneath the resident. *She removed her soiled gloves, performed hand hygiene, and placed a pair of clean gloves on her hands. With those gloved hands she: -Touched the resident's leg to reposition her. -Used an alcohol pad to clean the scissors and cut the Kerlix gauze to the length she needed. -Put the gauze in the cup with the Dakin's solution. -Put the packaged thick absorbent dressing directly on the bed linen, without a protective barrier, and opened the package. -Using the same gloved hands, she took the Dakin's-soaked gauze and packed it loosely into the resident's wound, covered the wound with the thick absorbent dressing, and repositioned the resident on her back. -RN/WCN C then removed her gloves, and without performing hand hygiene, fastened the sides of the resident's brief, and covered her with a blanket. Interview on 1/26/23 at 10:25 a.m. with director of nursing B revealed she agreed RN/WCN C should have used a barrier for all the dressing change supplies and under the resident. She agreed RN/WCN C had missed opportunities for	F 880		

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F 880	Continued From page 4 hand hygiene. Review of the provider's undated wound care policy revealed: "Preparation: 3. Assemble the equipment and supplies as needed. Date and initial all bottles and jars upon opening. Wipe nozzles, foil packets, bottle tops, etc. with alcohol pledget [pad] before opening, as necessary. Equipment and Supplies 1. Dressing material, as indicated, (i.e., gauze, tape, scissors). 2. Disposable cloths, as indicated. 3. Antiseptic (as ordered). 4. Personal protective equipment (e.g., gowns, gloves, mask, etc., as needed). Steps in the Procedure 1. Use disposable cloth (paper towel is adequate) to set up a clean field on resident's overbed table. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. 4. Put on exam glove. Loosen tape and remove dressing. 5. Pull glove over dressing and discard..... Wash and dry your hands thoroughly. 6. Put on [clean] gloves. 9. Wear exam gloves for holding gauze to catch irrigation solutions that are poured directly over the wound. 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 14. Remove the disposable cloth next to the resident and discard into the designated container.	F 880		

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F 880	Continued From page 5 15 ....Remove disposable gloves ... Wash and dry your hands thoroughly. 16. Reposition the bed covers. Make the resident comfortable. Use supportive devices [pillows, positioning wedge] as instructed. 20. Wipe reusable supplies with alcohol as indicated (i. e., outsides of containers that were touched by unclean hands, scissor blades, etc.) 22. Wash and dry your hands thoroughly."	F 880		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/23/23 through 1/26/23. Bethel Lutheran Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jermiah J. Schneider | TITLE: CEO | (X6) DATE: 10 Feb 2023

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	435076	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/24/23. Bethel Lutheran Home was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K321 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for alleged deficiencies cited during the survey that was conducted from 1/24/2023 through 1/26/2023. Please accept this plan of correction as Bethel Lutheran Homes Credible Allegation of Compliance with the completion date of 2/28/2023. The completion and execution of this plan of correction does not constitute admission of guilt or wrongdoing on the part of Bethel Lutheran Home. This plan of correction is completed in good faith as Bethel Lutheran Home commitment to quality outcomes for the residents. In addition, this plan of correction is completed as it is required by law.	
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 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	K321 (NFPA 101) Residents residing in the facility have the potential to be affected in the similar manner. The Healthcare Service Group (HCSG) housekeeping supervisor will be educated/re-educated on the Bethel Fire Policy as well as on the dangers of fire doors not closing. The HCSG Regional manager will add this to their orientation for ALL new housekeeping staff. Bethel Maintenance staff, DON, Administrator will all make daily rounds to ensure the door is not held open by means not part of the mechanical operation of the door.	13 Feb 2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jermiah J. Schneider | TITLE: CEO | (X6) DATE: 13 Feb 2023

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	435076	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/24/2023**

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

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K 321	Continued From page 1 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: Based on observation, testing, and interview, the provider failed to maintain one hazardous area (food storage/housekeeping) as required. Findings include: 1. Observation and testing on 1/24/23 at 10:52 a.m. revealed the food storage/housekeeping room was over 100 square feet and contained combustible items. The door from the housekeeping half of the 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. Further observation at that same time revealed the doors latching strike had been removed. 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	CONT from Pg1. Signage will be added to the door stating "DO NOT PROP DOOR OPEN" in large red ink. QAPI committee will add this to the monthly facilities section for 3 months to be tracked to ensure compliance with procedure.	
K 712	Fire Drills	K 712		

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K 712 SS=D	Continued From page 2 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (closing corridor doors and checking the door for the fire location). Findings include: 1. Observation beginning on 1/24/23 at 3:17 p.m. revealed a drill for a simulated fire in resident room West 3-W-1 was being conducted. Initially, only one staff person responded to the nurse call light in the simulated fire location. That staff person did not evacuate the resident from the affected room in a timely manner. Three and one-half minutes passed prior to the resident being evacuated by other staff. During the initial response, the resident tried helping the responding staff person by telling her "remember you have to close all the doors down the hallway". Despite sage advice from the resident, the responding staff person canceled the call light, walked out of the room, and down the corridor toward the west end without other action. When the responding staff person had made it	K 712	K 712 (NPFA 101) Residents residing in the facility have the potential to be affected in the similar manner. ALL staff will be educated/re-educated on the Bethel Disaster Plan which includes the Fire Plan. This education will also be a recurring topic at our bi-annual education fair. Paper (Hard) copies of the Emergency Preparedness Plan which includes the Fire Plan will be placed in the following locations: Nursing Station, Maintenance Office, Business Office and DON Office. A larger emphasis will be placed on Fire Drill during New Hire Orientation for both organic staff and Agency (Temp) staff so everyone understand the process. During orientation there will be a "Fire Drill" as part of their General Orientation. ALL staff will receive RACE/PASS card to be added to their ID badges to allow for a quick reference in the event of a Fire. Maintenance Director or designee will track all fire drills and provide an after action report to the QAPI committee on a monthly basis.	13 Feb 2023

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K 712	Continued From page 3 approximately three-quarters of the way down the west corridor the maintenance supervisor intervened to ensure the responding staff person would complete the required steps of the drill. Interview with the maintenance supervisor at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants.	K 712		

South Dakota Department of Health

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	10644	A. BUILDING: _____ B. WING _____	01/26/2023

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/23/23 through 1/26/23. Bethel Lutheran Home was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/23/23 through 1/26/23. Bethel Lutheran Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jermiah J. Schneider — TITLE: CEO — (X6) DATE: 10 Feb 2023

STATE FORM 6899 — If continuation sheet 1 of 1

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