STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/3/20 through 2/5/20. Bethesda of Beresford was found not in compliance with the following requirements: F610 and F880.	F 000		
F 610 SS=E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Surveyor: 29354 Based on observation, interview, record review, policy review, staffing contract agreement review, personnel file review, and education training review, the provider failed to ensure:	F 610	F610 - Investigate/Prevent/Correct Alleged Violation 1. Investigation for incident with Resident 31 was completed during the state survey. Staff member I is no longer employed at Bethesda of Beresford. Staff member H has completed her orientation training as of 2-26-2020 and the checklist has been placed in her employee file. Incident reports for Resident 31 and 38 were reported to the Department of Health. 2. Residents who have events that meet the required state reporting guidelines are at risk. 3. Facility policy was reviewed on 2-24-2020. All facility staff will be re-educated on the policy of mandatory reporting requirements by 3-5-2020 by the Administrator and / or designee. The facility policy on Elopement was reviewed and updated on 2-27-2020. All facility staff will be re-educated on the elopement policy by 3-5-2020. 4. Audits will be conducted for 3 months on all event reports to ensure proper reporting. Audits will be conducted by the Administrator and/or Designee to ensure proper reporting compliance. Audit findings will be reported to the QAPI committee monthly x 3 months by the Administrator to determine if compliance has been met or if further interventions are needed.	3-23-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cherilyn Hallaway
TITLE: Administrator
(X6) DATE: 2-27-2020

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F 610	Continued From page 1 *A thorough investigation had been completed and documented for: -One of one sampled resident (31) who had allegedly been denied personal care assistance by one of one temporary (temp) agency certified nurse aide (CNA) (I). -One of one sampled resident (38) who had eloped. *Abuse and neglect education had been provided and completed for one of one licensed practical nurse (LPN) (H) upon hire and CNA (I) with initiation of staffing contract. *Accurate and timely reporting to South Dakota Department of Health (SD DOH) of alleged denial of care of resident 31 and elopement from the facility of resident 38. Findings include: 1. Review of resident 31's medical record revealed: *His 12/17/19 quarterly Minimum Data Set assessment revealed: -His Brief Interview for Mental Status score of fourteen; indicating he was cognizant. -Braden Scale of fourteen; indicating he was at risk for developing pressure injuries. *He had diagnoses of chronic kidney disease, stage 2 (mild), retention of urine; urinary incontinence; urgency of urination; and as of 12/9/19, acute cystitis. *He was taking three medications for urinary incontinence, urine retention and fluid retention, and an antibiotic for a urinary tract infection. *He was being treated for unhealed pressure injuries on his buttocks and other moisture associated skin damage. *He required the use of a stand aid mechanical lift with 2 person assistance for transfers.	F 610		

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F 610	Continued From page 2 Interview on 2/3/20 at 1:31 p.m. with resident 31 and his wife revealed: *Six weeks ago he had to go to the bathroom, a traveler CNA had told him to go in his pants, and they would clean him up in the morning. -That event had occurred around 4:00 a.m. -They had told their daughter about it. -Their daughter had reported it but they were unsure who too. *He had open sores on his bottom. *He slept in his recliner and required assistance with repositioning. *He used a stand aid mechanical lift for transfer. *While he could not remember the name of the traveler CNA, he could remember and describe her, referencing age, style and color of her hair. Interview on 2/3/20 at 4:44 p.m. with administrator A and director of nursing (DON) B regarding the above incident with resident 31 revealed: *The administrator was not aware of the event. *Temp agency CNA I: -Had been reeducated by the night nurse following the incident according to the DON. -Continued to work until her contract was up, then she was no longer employed at the facility. -Had been reeducated the next day by the DON following the incident *The family had not filled out a grievance report. *The DON had found out about the incident by one of the other CNAs. *They had not completed any documentation regarding the incident. *They had not reported the incident to the South Dakota Department of Health (SD DOH). *The DON had not considered it neglect. *The administrator stated she would have considered it neglect.	F 610		

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F 610	Continued From page 3 *They should have reported the incident to the SD DOH. *They had used it as an education piece. *They had not completed an incident report. *CNA I had continued to care for him after the incident. Interview on 2/3/20 at 4:55 p.m. with social services designee/registered nurse (RN) J regarding the above incident with resident 31 revealed: *She had been informed about the above incident by the resident on 1/30/20 or 1/31/20. *The incident could be considered neglect. *The temp agency employer had been notified of temp agency CNA I regarding the above event through an email sent by director of human resource K on 1/31/20. *She was not aware if the temp agency employer had been contacted previously about the incident. *She was not sure if the incident should have been reported to the SD DOH. Interview on 2/3/20 at 5:15 p.m. with infection control/RN C regarding the above incident with resident 31 revealed: *She been informed of the incident on 1/31/20. *A CNA had come into her office and told her about it. Continued interview on 2/3/20 at 5:49 p.m. with DON B regarding the above incident with resident 31 revealed: *It had occurred the middle of December 2019. -She could not remember the exact date of the incident. *LPN H: -Had been on duty when the incident occurred. -She had visited with temp agency CNA I	F 610		

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F 610	Continued From page 4 regarding the incident. -She had instructed CNA I to return to his room and assist him with toileting which she had done. *As the DON she had reeducated CNA I the following day. *She had not documented the incident. *She was aware he had a urinary tract infection in December 2019. Surveyor 41895 Interviews on 2/5/20 between 9:58 a.m. and 12:55 p.m. with director of human resource (HR) K revealed: *LPN H had worked the night shift and was to watch the new hire education videos on her own. *After LPN H had completed the videos she was to complete the Education Materials check list, sign it, and return it to the director of human resource K. -There was no documentation that had been done. Surveyor 29354 Telephone interview on 2/5/20 at 10:55 a.m. with LPN H regarding the above incident with resident 31 revealed: *She had been employed since July 2019. *She had worked the night shift, then the day shift, and was now working both to help with nursing coverage. *She recalled the incident happening around December 17, 18, or 19 but was unsure of the exact date. *CNA I had been fairly new. *She had been working down his hallway. *She had asked CNA I what he had wanted. -CNA I had: --Stated he wanted to go to the bathroom. --Told him to go in his brief.	F 610		

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F 610	Continued From page 5 *She had reeducated CNA I that they did not do that. -To use her pocket care plan. -CNA I then toileted him. *She had: -Informed DON B the next day regarding the above incident. -Documented the incident on a piece of paper and had given it to the DON. -Not completed any formal documentation regarding the above incident. Review of the 12/20/19 incident report documentation received from the DON regarding the above incident with resident 31 revealed: *She had received a note from an aide on 12/19/19. *She had received a call from LPN H on 12/19/19 regarding the incident. *She had spoken to the temp agency regarding the incident with CNA I. *She had spoken with CNA I on 12/20/19 regarding the incident. *She had informed CNA I where the care plans and pocket care plans were located. -Reviewed with her how to read them. *She had followed up with LPN H on 1/7/20 on how temp agency CNA I was doing. Review of the December 2019 nursing/CNA schedule revealed LPN H and CNA I had worked together on the night shift December 17, 2019. Review of the agreement between the temp agency and the provider revealed: -"Client Facility Responsibilities: --D. Client Facility agrees that a proper orientation will be conducted to ensure a safe working environment."	F 610		

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F 610	Continued From page 6 Review of the Helpful Tips and Expectations of Bethesda and interview with administrator A on 2/5/2020 at 11:30 a.m. regarding orientation of temp agency staff revealed: *They were given a packet with information. -It had not included information on abuse and neglect. *They had not had a formal orientation for temp agency staff. *CNA I: -Had not received education on abuse and neglect. -Her contract had ran from 11/27/19 through 1/24/20. Review of temp agency CNA I's agency education and competencies documentation revealed: *She had received competencies in toileting and elimination. *There was no documentation she had received training on abuse and neglect. Surveyor 41895 Review of LPN H's employee file on 2/5/20 revealed: *She was hired on 9/22/19. *There was no documentation of new hire education having been provided upon being hired. Surveyor 29354 Review of the 1/31/20 at 1:00 p.m. email sent by HR K to the temp agency regarding the above incident that occurred with resident 31 revealed: *They "wanted to reach out and let you know that we receive a care complaint against [temp agency CNA I name] from a resident." *"This is an older complaint, but he didn't bring it	F 610		

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F 610	Continued From page 7 up because he didn't want to get anyone in trouble." Interview on 2/5/20 at 1:15 p.m. with administrator A and DON B regarding resident 31's incident revealed they agreed they had not: *Conducted or documented a complete investigation. *Reported the incident to the SD DOH. Surveyor: 42477 2. Interview on 2/3/20 at 1:55 p.m. with resident 38 and her power of attorney (POA) revealed: *She was currently receiving hospice services. *She had an alarm device on. *She had wandered outside of the facility on more than one occasion. *POA felt that resident 38 was being observed more closely than when she was previously at another facility. Review of resident 38's medical record revealed: *She was admitted on 6/18/2019. *Her diagnoses included: -Alzheimer's disease. -Respiratory failure. -Dementia. -Major depressive disorder. -Anxiety disorder. Review of resident 38's 1/9/20 care plan revealed: *The facility care planned an approach due to her wandering. -Approach:"At times I do go to the doors and open them and leave. I do have a wander guard on in case I forget that I should have staff go with me outdoors. I push on the doors until I get	F 610		

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F 610	Continued From page 8 through them and then attempt to get outdoors, I have gotten out of the building before. If you hear the Wanderguard alert going off please check to ensure that I am not by the doors. I pack my clothes and belongings on my walker sometimes when I am going to leave. It has been noted that I am less likely to go down a dark hallway towards a door, if I am trying to leave out the front door it may help deter me to shut the light off in the front hallway in the evenings." Review of resident 38's nursing progress notes revealed: *She had wandered outside of the facility on the following dates: *On 7/21/19 at 1:12 p.m.: "Resident had gotten out the front door today behind visitors and was brought in by hospice nurse who was coming into the building." *On 8/12/19 at 7:30 p.m.: "Resident went out front door and Wanderguard did go off and by the time staff got to resident she was walking on sidewalk in front of building. Another resident was out there and talk with her until staff arrived. Resident does have a history of packing belongings and repeatedly setting off the alarms of secured doors. Resident is easily redirected. No injuries noted. Wanderguard is functioning properly." *On 12/29/19 at 7:44 p.m.: "Resident had been near front door often, occasionally pushing on it and setting of the alarm. At one point around 1310 [1:10 p.m.] when she had made it back down there she set off alarm and when nurse ran down she had already made it out the front door and was standing just outside of the door on the front walkway. Was easily redirected back inside. Was pleasant today. POA/[POA's name] notified at this time of this."	F 610		

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F 610	Continued From page 9 Elopement reports and investigations were requested from administrator A on 2/5/20 at 11:30 a.m.. Later that afternoon DON B revealed they did not have elopement reports or investigations for the above mentioned incidents for resident 38. This included the South Dakota Department of Health being notified. Review of the provider's October 2019 Missing Resident and Elopement policy revealed: *"Policy: It is the policy of [facility name] to promote the safety and well-being of our residents. Preventative measures are the first ways to stop residents from wandering off. Aides should always be accounting for residents in their area. All staff members should be watching carefully those residents known to be 'wanderers'." *Review of the policy's procedures regarding finding a resident missing included: -"Elopement: Any individual away from the facility without staff knowledge of department or exit time or destination." Surveyor 29354 Review of the provider's 1/7/19 Abuse Prevention, Identification, Investigation, and Reporting policy revealed: *"Purpose: -Residents have the right to be free from verbal, sexual, physical, mental abuse, neglect misappropriation of property, corporal punishment, exploitation and involuntary seclusion. *Definitions: -Neglect: --Is a failure, through inattentiveness, carelessness, seclusion, or omission, without a reasonable justification to provide timely,	F 610		

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F 610	Continued From page 10 consistent and safe services, treatment and care to a patient/resident. *Policy: -To protect both the vulnerable adult and staff from abuse and neglect. -To require facility staff to report suspected abuse or neglect of vulnerable adults. --To require the investigation of any and all reports. -To have all staff knowledgeable of this plan and the mechanism for reporting suspected abuse or neglect by orienting new staff to this policy and providing at least annual education to staff on abuse and reporting. -The facility will provide ongoing oversight and supervision of staff to assure implementation of this policy as it is written. *How to report suspicion of abuse and/or neglect. -Immediately notify the Administrator, Directory of Nursing (DON), Social Worker, or any Department Manager. -If an incident occurs outside their regular hours, report to the supervising nurse who will assure reporting the Administrator or DON. *An initial and final electronic report within 5 days will be made within SD DOH guidelines for reporting."	F 610		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		

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F 880	Continued From page 11 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880	F 880 - Infection Prevention & Control 1. Staff member's D, E, G have been re-educated by the Director of Nursing / Infection Control Nurse on 2-26-2020 regarding proper hand hygiene, infection control procedures, catheter cares, and dressing changes. 2. All residents could be affected. 3. All nursing staff were re-educated on 2-26-2020 by the Director of Nursing / Infection Control Nurse on the importance of proper hand hygiene and infection control during wound dressing changes and catheter cares. 4. Audits monitoring 3 employees hand washing, dressing changes, and catheter cares will be performed by the Director of Nursing and/or the Infection Control Nurse weekly x 3 weeks, and then monthly x 2 months. The results of the audits will be brought to the QAPI committee monthly by the Infection Control Nurse to determine if compliance has been met or if further interventions and education are needed.	3-23-2020

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F 880	Continued From page 12 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on observation, interview, and policy review, the provider failed to ensure infection control technique and practice were maintained for: *Hand hygiene and glove use during a Foley catheter change for one of one sampled resident (49) by two of two observed registered nurses (RN) (D and E). *Two of two sampled residents (22 and 31) by two of two observed licensed nurses (D and G) during two of three observed dressing changes. Findings include: 1. Observation on 2/3/20 at 3:33 p.m. in resident 49's room with RNs D and E revealed: *They both performed hand hygiene and put on gloves. *RN E placed the supplies on the overbed table without putting a barrier underneath them or	F 880		

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F 880	Continued From page 13 disinfecting the table. *RN D took a syringe, had not cleaned off the Foley catheter tip, and removed 8 milliliters (ml) of water from the balloon. *RN E removed a new Foley drainage bag from the package, put it directly on his bed, and then placed a towel by his perineum. -Removed her gloves and did not perform hand hygiene. -Attached the new Foley drainage bag to the side of the bed. -Put on sterile gloves. *RN D took a paper drape from the package and placed it next to his perineum area. -Opened the package of betadine and handed it to RN E. -Removed his current Foley catheter and laid it on the paper drape. *RN E wiped the penis opening with three betadine swabs. *RN D picked up the old Foley catheter and repositioned it on the paper drape. -With those same gloves on she opened a package of sterile lubricant. *RN E put that sterile lubricant on the insertion end of the Foley Catheter. -Then inserted the Foley catheter. *RN D attached the end of the new Foley catheter to the urine drainage bag. -Took a sterile syringe and injected 10 ml of water into the Foley catheter balloon. -Discarded the catheter insertion tray and items, and removed her gloves. Interview on 2/3/20 at 3:56 p.m. with RNs D and E regarding the above observation of resident 49 revealed: *RN E: -Had not been trained to do hand hygiene	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 between changing gloves. -Would need to check their policy regarding catheter insertion. *RN D could see where she should have done hand hygiene when going from dirty to clean to sterile. Interview on 2/5/20 at 1:00 p.m. with director of nursing (DON) B and administrator A regarding the above observation of resident 49 revealed: *RN D should have changed gloves and completed hand hygiene. *RN E should have done hand hygiene. *Their policy had not specified when to do hand hygiene and change gloves. Review of the provider's 5/24/18 Catheter Insertion, Male policy revealed it had not included information on hand hygiene prior, during, or after the procedure. 2. Observation and interview on 2/4/20 at 7:05 a.m. in resident 31's room with licensed practical nurse (LPN) (G) revealed: *He had a wound on his coccyx area caused from his incontinence. *She gathered the supplies from the treatment cart. *Without performing hand hygiene she put on gloves. *The resident was sitting on the toilet. -The stand-assist mechanical lift was attached to him. *She laid the supplies on the back of the toilet without putting a barrier under them. *She assisted him to stand-up with the mechanical lift. *She went behind him and began to wipe his buttock area with several wet wipes.	F 880		

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	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

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F 880	Continued From page 15 -There was a small visible area of fecal matter on her glove. *With those same gloves on she: -Took the wound wash and sprayed the wound areas on each side of his anal crease. -Opened up the package of collagen and applied it to both sides of the open wounds. *She removed her gloves, performed hand hygiene, and put on new gloves. -Applied a dressing to both sides of the anal crease wounds. -Removed her gloves and performed hand hygiene. Interview on 2/5/20 at 1:04 p.m. with DON B and administrator A regarding the above observation of resident 31 revealed there were some missed hand hygiene opportunities. Surveyor: 42477 3. Observation on 2/5/20 at 7:50 a.m. with RN D in resident 22's room during a dressing change revealed: *She was not aware if the wound was currently infected or if she had been on antibiotics. *They used contact precautions when someone had an active infection. *She had not completed hand hygiene after she entered the resident's room. She laid the dressing supplies on her bedside table without disinfecting or laying a barrier down first. -Picked the dressing supplies up and went into the bathroom to get paper towels. -Came out of to the bathroom, laid the paper towels down on the bedside table, and laid the supplies on top of the paper towels. -Stated she had "rinsed" her hands off when she	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 was in the bathroom. -Put on gloves. -Put her thumb inside of the trash can and moved it closer to her. -Touched her soiled dressing. *With those same glove on she began to open the clean supplies. -Removed the soiled dressing. -Removed her gloves. *Without performing hand hygiene put on new gloves. -Sprayed the wound with wound cleanser. -Applied a 4 by 4 gauze on the wound area. -Placed a Mediplex dressing on the wound area. -Removed her gloves. -Took out the trash. -Then used hand sanitizer upon leaving the room. Surveyor 29354 4. Interview on 2/5/20 at 2:11 p.m. with infection control nurse C regarding their infection control policies and procedures revealed they reviewed them annually and updated them as needed. Review of the provider's 9/14/06 Wound Dressing Change (Non-sterile) policy revealed: *Purpose: -"To absorb drainage. -To prevent infection. -To assess healing process. -To promote healing of wound." *Procedure: -"2. Wash hands. -4. Put on gloves. -6. Remove soiled dressing and discard in plastic bag. -7. Remove gloves and put on second pair of gloves. -8. Cleanse area.	F 880		

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	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

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F 880	Continued From page 17 -9. Apply new dressing. -11. Remove gloves and wash hands." Review of the provider's 11/8/14 Hand Hygiene policy revealed: *Purpose: -"Hand hygiene is the single most important strategy to reduce the risks of transmitting organisms from one person to another or from one site to another on the same resident. -Cleaning hands promptly and thoroughly between residents contact and after contact with blood, body fluids, secretions, excretion, equipments and potentially contaminated surfaces is and important strategy for prevention healthcare-associated infections." *Procedure: -"1. Hand Hygiene should be performed: --Upon entering and exiting a resident room. --Before and after resident contact, including dry skin contact. --After removing gloves. --Before performing invasive procedures. --Before and after contact with wounds. --After contact with residents' body substances. --After handling equipment, supplies, or linen contaminated with body substances. --Before handling sterile or clean supplies. --When hands are visibly soiled. --When moving from contaminated to clean sites or areas." Review of the provider's 11/8/14 Glove Use policy revealed: *Indication for glove removal: -"When there is an indication for hand hygiene (when moving from a dirty to a clean area or site, if gloves contaminated by resident or environment prior to performing a procedure/resident care)."	F 880		

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	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

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	435080	A. BUILDING _____ B. WING _____	02/05/2020

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BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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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 2/3/20 through 2/5/20. Bethesda of Beresford was found not in compliance with the following requirement: E001.	E 000		
E 001 SS=E	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The	E 001	E001 - Establishment of the Emergency Program 1. The Emergency Preparedness Plan has been revised as of 2-27-2020 to include... -Policies & Procedures for staff, residents, and pharmaceutical supplies -Policies & Procedures for sheltering in place for residents, staff, and volunteers who remained in the long term care facility - The use and role of volunteers in the P&P - Developed and maintained a communication plan - Developed a communication plan that included names and contact information for staff, residents' physicians, other long term care facilities, and volunteers - Conducted training, testing, or drills related to EP 2. All residents and staff could be affected. 3. All will be educated on the EP by the Administator and Director of Enviromental Services by 3-5-2020. 4. Audits monitoring the updating and continued planning for emergency preparedness will be performed monthly by the Administrator or Director of Enviromental Services. The results of the audits will be brought to the QAPI committee monthly by the Administrator to determine if compliance has been met or if further interventions and education are needed.	3-26-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cherilyn Hallaway | TITLE: Administrator | (X6) DATE: 2-27-2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING _____ B. WING _____	02/05/2020

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

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E 001	Continued From page 1 emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on interview and record review, the provider failed to establish a comprehensive emergency preparedness program. Findings include: 1. Interview on 2/5/20 at 2:50 p.m. and review of the provider's emergency preparedness program documentation with administrator A and director of environmental service F revealed: *They did not have a complete emergency preparedness program. *They had not: -Addressed policies and procedures for staff and residents for pharmaceutical supplies -Addressed policies and procedures for sheltering in place for residents, staff, and volunteers who remained in the long term care facility. -Addressed the use and role of volunteers in their policies and procedures. -Developed and maintained a communication plan and reviewed and updated it at least annually. -Developed a communication plan that had included names and contact information for staff, residents' physicians, other long term care facilities, and volunteers. -Conducted training, testing, or drills related to emergency preparedness.	E 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/04/2020

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BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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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 2/4/20. Bethesda Of Beresford 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 deficiency identified at K133 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 133 SS=D	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider	K 133	K 133 1. The door handle of the door was replaced on 2-6-2020. 2. All residents are at risk. 3. The Maintenance Supervisor is aware and has been reeducated as of 2-27-2020 by the Administrator on the importance of keeping the fire wall sealed. 4. The Maintenance Supervisor or designee will audit the closing of the fire rated doors monthly x 3 to ensure no breach in the fire wall. The Maintenance Supervisor will report the findings of the audit to the QAPI committee monthly to determine if compliance is being met or if further interventions are needed.	3-16-2020

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

TITLE
Administrator

(X6) DATE
2/27/2020

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

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	435080	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/04/2020**

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BETHESDA OF BERESFORD	**606 W CEDAR** **BERESFORD, SD 57004**

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K 133	Continued From page 1 failed to maintain the fire-resistive design of one randomly observed building separation wall (between the nursing home and the independent living). Findings include: 1. Observation at 2:19 p.m. on 2/4/20 revealed the door for the two-hour, fire-rated separation wall between the nursing home and the independent living was not latching into the door frame with normal operation. That door is required to latch into the frame to maintain the fire rating of the separation wall. Interview with the environmental services director at the time of the observation confirmed that finding. The deficiency could affect 100% of the occupants of the smoke compartment.	K 133		

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
	10595	A. BUILDING: _____ B. WING _____	02/05/2020

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BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

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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 2/3/20 through 2/5/20. Bethesda of Beresford was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 27198 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 2/3/20 through 2/5/20. Bethesda of Beresford was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cherilyn Hallaway

TITLE: Administrator

(X6) DATE: 2-26-2020