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
	435130	A. BUILDING _____ B. WING _____	C 04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

(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 4/25/22 through 4/27/22. Bethany Home - Brandon was found not in compliance with the following requirements: F656 and F842. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/25/22 through 4/27/22. Areas surveyed included quality of care/treatment, resident neglect, and dietary services. Bethany Home - Brandon was found in compliance.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	F 656: Life Enrichment Coordinator H will meet with resident 17 to discuss their preferences for activities and how the facility can best help meet their desires and preferences and that they are reflected appropriatley in the resident's care plan. Life Enrichment Coordinator H will audit all resident care plans beginning 05/23/2022, to ensure that preferences for activities are included in the resident's comprehensive care plan. If any residents are found to not have preferences listed, Life Enrichment Coordinator H will consult with the resident to discuss their activity preferences. IDT reviewed and revised the policies and procedures, as necessary,on 05/18/2022 relating to resident activities and care planning. Life Enrichment Coordniator H will hold a directed inservice for all staff on 06/08/2022 to provide education related to resident activities and care planning. Life Enrichment Coordinator H or designee will audit one resident care plan a week for 3 months to ensure resident activity preferences are included in the resident's comprehensive care plan. Life Encrichment Coordinator H will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	06/16/2022

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

TITLE
Administrator

(X6) DATE
05/17/2022

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 656	Continued From page 1 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to develop person-centered care plans, and revise as needed, to address interventions and resident preference for four of fourteen sampled residents (17, 27, 44, and 55). Findings include: 1.Observation and interview on 4/26/22 at 10:35 a.m. with resident 17 revealed he: *Had been lying in bed in a dark room. *Had not participated in activities outside of his room. *Preferred to stay in his room to watch TV, read or write. *Had been receiving physical therapy since admission on 1/31/22. *Ate his meals in his room.	F 656	IDT will review Resident 44's care plan to ensure that the care plan reflected the need to protect him from wandering out of the secured memory unit. IDTaddressed the need to ensure that the doors on the memory care unit are properly latched so the residents cannot exit the unit. Facility maintenance director audits door latches once a month. HNW 06/07/2022. Starting the week of 05/23/2022, Facility nurse managers audited all resident care plans to ensure that any resident in need of elopement cessation measures had those measures included in their care plan. IDT reviewed and revised, as necessary, the policies and procedures relateing to resident elopement and care planning on 05/18/2022. DON or designee will present a directed inservice to RN F and all staff on 06/08/2022 relating to resident elopement and care planning policies and procedures. Beginning 05/23/2022, facility nurse managers will audit one resident care plan a week for three months to ensure that residents who require elopment cessation measures have those measures included in the care plan. Facility nurse managers will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation. Facility nurse managers will review all resident care plans to ensure that those residents on hospice had that need and the need for comfort measures included in the resident's comprehensive care plan. IDT reviewed and revised, as necessary, the policies and procedures related to hospice care plans on 05/18/2022. DON or designee will present a directed inservice to RN F and all staff on 06/08/20220 relating to hospice care planning Beginning 05/23/2022, Facility nurse managers will audit all hospice resident care plans once a week for 4 weeks and monthly for two more months to ensure the resident's need for hospice is included in the comprehensive care plan. Facility nurse managers will present the findings of the audits to the QAPI committee at their quarterly meeting for review and recommendation. IDT reviewed resident 27's care plan to include more individualized fall prevention tasks on their comprehensive care plan the week of 05/23/2022. Facility nurse managers reviewed all resident care plans to ensure residents requiring fall interventions had updated interventions listed on the comprehensive care plan the week of 05/23/2022. IDT reviewed and revised, as necessary, the policies and procedures related to fall prevention and care planning on 05/18/2022. DON or designee will present a directed inservices to RN L and all staff on 06/08/2022 relating to the policies and	

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F 656	Continued From page 2 Review of resident 17's care plan date initiated 2/7/22 created by registered nurse D (RN) revealed he: *Preferred to consume meals in my room, but staff were to encourage me to eat one meal per day out in the dining room. *Had no preferences for activities. Interview on 4/27/22 at 11:14 a.m. with life enrichment coordinator H regarding resident's activities revealed: *She had known that he preferred to be in his room. *Would provide in- room activities such as: puzzles, books. -But had not done that. *Had visited with the resident in his room, which he liked. *She would complete an evaluation on new admissions within 48 hours. *She would re-evaluate a resident if they had not participated in activities and update the care plan. *She agreed that resident's care plan did not address activities that he had preferred or enjoyed. *She agreed that no evaluation had been completed since his admission. 2.Observation on 4/26/22 10:06 a.m. of resident 44 revealed he: *Had been feeding himself breakfast. *Had been able to answer some questions. Observation on 4/26/22 at 2:57 p.m. of resident ambulating on the unit. Record review of resident 44's chart revealed: *Admitted to memory care unit with diagnosis of	F 656	procedures of fall prevention and care planning. Beginning 05/23/2022, facility nurse managers will audit one resident care plan a week for 3 months to ensure that the resident has fall interventions in place. Facility nurse managers will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	

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F 656	Continued From page 3 Alzheimer's disease. *Had eloped from the memory care unit on 4/10/22,and was found within the facility. Review of resident 44's care plan dated 5/5/21 revealed: *He had attempted to leave previous facilities unattended. *Had been a fall risk. *High risk for wandering. *Preferred BINGO, reading the newspaper, visiting and movies to distract from wandering. *Provide structured activities. *Identify pattern of wandering. *No intervention for frequent rounding. Interview on 4/27/22 at 8:56 a.m. with registered nurse (RN) F revealed they/she: *Had placed a note on doors to memory care unit to make sure the door closed. *Did frequent checks on the resident, but that was not documented. *Agreed that frequent rounding was not on the care plan. *Had the resident been out of view, staff would look for him. *He did not have a wander guard. *Typically wander guard had not been used on a locked unit. 3.Closed record review of resident 55's chart revealed: *Had utilized hospice services on 2/28/22. *Passed away on 3/9/22. Review of resident 55's care plan initiated 5/31/17 revealed: *Had not been updated to reflect hospice services.	F 656		

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F 656	Continued From page 4 *Had not been updated to focus on areas such as: -Comfort measures. Interview on 4/27/22 at 4:47 p.m. with RN F regarding resident 55's care plan revealed: *Agreed that the care plan had not been updated to reflect that the resident had been on hospice. *Should have been updated to reflect resident's current plan of care. Interview on 4/27/22 at 5:46 p.m. with director of nursing B regarding resident 55's care plan revealed she: *Agreed that resident's care plan had not mentioned being on hospice. Review of providers Policy of Care dated 3/20 revealed: *Care plans would be individualized and developed with seven days of the comprehensive assessment. *Care plans would be updated by staff on an ongoing basis. 4. Observation on 4/27/22 at 10:03 a.m. revealed resident 27: *Standing in his room beside the right side of his wheelchair alone. *Held onto the wheelchair handle with his left hand. *Bent down to lock the brake on the right wheel with his right hand. *Stepped slowly to the front of his wheelchair and sat down. *Wheeled himself using his feet towards the bathroom in his room. Observation and interview on 4/27/22 at 10:10	F 656		

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F 656	Continued From page 5 a.m. revealed RN L: *Walked into resident 27's and was heard saying, "[Resident name}, "What are you doing?" *Left the room a few minutes later and explained that he had "self-transferred" onto the toilet and she helped him get back into his wheelchair. Interview on 4/27/22 at 10:20 a.m. with RN L revealed: *She had brought him to his room after he was done eating breakfast. *He had said he did not need to use the toilet but said he wanted to lie down. *He would not remember when he had previously used the toilet and was "typically up and down." *She agreed his care plan should be more individualized to describe his risk for falls and person-centered interventions. Review of the care plan revealed separate but overlapping interventions and tasks: *A focus created on 3/8/22 of "moderate risk for falls" that did not: -Identify the specific risk factors for resident 27. -State specifically how to "anticipate and meet my needs." -State in what type of physical activity staff should "encourage" the resident to participate. -Address the causes to remove based on a review of past falls. *A separate focus created on 3/9/22 and revised on 3/11/22 of "elopement risk/wanderer" included a physical activity of "walking inside and outside." *Another separate focus created on 3/9/22 and revised on 3/11/22 of "impaired cognitive function/thought processes" included activity preferences for exercise ("kick ball, balloon volleyball, noodleball").	F 656		

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F 656	Continued From page 6 Review of nursing progress notes revealed the resident had been found lying on the floor on: *3/19/22 at 1:44 p.m., in the "area before the door" and he said he did not know what happened. *4/11/22 at 6:08 a.m., "between bed and the wall with a noted smell of BM [bowel movement]." When asked if he needed to use the bathroom, the resident replied, "I think I already have." *4/17/22 at 9:50 a.m., "in walkway in front of door" with his wheelchair behind him. He said, "I was trying to walk."	F 656		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842	F 842: Resident 38 was assessed for skin integrity concerns on 05/2/2022 and their treatment record was updated to relfect any changes in their TAR. HNW 06/07/2022. Beginning the week of 05/30/2022, facility nurse managers will assess all residents for skin integrity concerns. If any new concerns or changes are found the resident's TAR will be updated. IDT reviewed and revised, as necessary, the policies and procedures relating to Skin Assessments, Pressure Ulcer Care, and care documentation on 05/18/2022. DON or designee will present a directed inservice for RN D, RN L, and all staff on 06/08/2022 regarding Skin Assessments, Pressure Ulcer Care, and care documentation. Beginning the week of 05/30/2022, facility nurse managers will audit resident skin assessment and pressure ulcer documentation to ensure staff are properly documenting care and appearance of the skin concerns. Audits will be once a week for three months. Facility nurse managers will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	06/16/2022

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F 842	Continued From page 7	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 8 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure consistent and continuous documentation for pressure ulcer monitoring for one of three sampled resident (38) with a pressure ulcer. Findings include: 1. Interview on 4/26/22 at 3:09 p.m. with resident 38 revealed he did not have any open areas that were currently being treated. Review of the treatment administration record (TAR) for resident 38 revealed orders dated: *6/28/21 to "complete a full skin assessment...every day shift every [Monday]." *3/24/22 to "assess Stage 2 pressure injury to right buttock - document appearance and if dressing is not to be changed, document appearance of dressing every day shift." Review of the weekly full skin assessment "eMAR - Medication Administration Note" revealed: *On 3/21/22, a "quarter size open area to [right] buttock" was found "after tub bath." *There were no documented measurements of the open area on that date or in the weekly skin assessment notes after that date. *There was inconsistent documentation regarding the color and odor of any drainage and color and character of the tissue and wound edges. *The weekly assessment on 4/18/22 was missed. *The 4/25/22 noted no documentation regarding the buttock wound. Review of the eMAR notes between 3/24/22 and 4/27/22 to "assess Stage 2 pressure injury" as	F 842		

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F 842	Continued From page 9 ordered on 3/24/22 revealed: *There were no documented measurements of the open area. *Descriptions for the appearance of the Stage 2 pressure injury were inconsistent, seldom included the condition of the dressing, and did not address whether pain was present. *The eMAR notes for this order were intermixed among eMAR notes related to other orders making it difficult to determine the progress of healing. *Four daily eMAR notes were missed, including 4/8/22, 4/12/22, 414/22, and 4/22/22. Further review of nursing progress notes revealed a weekly "Health Status Note" that documented measurements of the pressure ulcer: *On 3/23/22, the pressure ulcer was assessed and measured at 2.5 x [by] 3.5 cm [centimeters], with a "beefy red" color, moderate drainage, "macerated surrounding," skin was moist, and there was no odor. *On 3/30/22, the measurements were 0.6 x 1.5 cm with a "pink wound bed. Surrounding tissue is pink in color as well and blanches. No drainage noted with assessment. Resident reports no discomfort with assessment, but does flinch when assessment is completed." *On 4/6/22, the measurements were 1.1 x 0.8 cm, Color, wound bed, drainage, odor, and pain were all documented. *On 4/13/22, no measurements were documented, although the wound is described as "fragile" and "blanching." *There were no further health status notes after 4/13/22. Interview 4/27/22 at 3:54 p.m. with registered nurse (RN) D and RN L revealed the process for	F 842		

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F 842	Continued From page 10 documentation of skin and pressure ulcer monitoring included: *A weekly full skin assessment is completed by a nurse on a resident's bath day. The nurse reports if an open area is found. *The neighborhood leaders would document weekly measurements and assessment of the wound. *The floor nurses would document daily on the appearance of the dressing and status of the area visible around the dressing or under the dressing if the dressing needed to be changed. *They agreed the documentation system made it difficult to assess progress towards healing. Review of the Pressure Ulcer Monitoring and Documentation policy, reviewed on 2/2021, revealed: *"When a PU/PI [pressure ulcer/pressure injury] is present, daily monitoring, (with accompanying documentation...), should include: 1. An evaluation of the PU/PI, in no dressing is present. 2. An evaluation of the status of the dressing, if present... 3. The status of the area surrounding the PU/PI... 4. The present of possible complications... 5. Whether pain, if present, is being adequately controlled. 6. The amount of observation possible will depend upon the type of dressing that is used... 7. With each dressing change or at least weekly...an evaluation of the PU/PI should be documented..." and include location, staging, size, drainage, pain, color and character of the wound bed tissue, description of the wound edges and surrounding tissue.	F 842		

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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 4/25/22 through 4/27/22. Bethany Home - Brandon was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winklepleck
TITLE: Administrator
(X6) DATE: 05/16/2022

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
	435130	A. BUILDING **01 - MAIN** B. WING _____	**04/26/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME - BRANDON	**3012 E ASPEN BLVD BRANDON, SD 57005**

(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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/26/22. Bethany Home - Brandon was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 05/16/2022

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.

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
	10677-2	A. BUILDING: _____ B. WING _____	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

(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: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/25/22 through 4/27/22. Bethany Home - Brandon was found not in compliance with the following requirements: S166, S169, and S236.	S 000		
S 166	44:73:02:18(1-2) Occupant Protection The facility shall take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents; (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system shall be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation, and interview, the provider failed to adequately maintain cross corridor fire doors to preclude excessive closure speed. Findings include: 1. Observation on 4/26/22 at 1:30 p.m. revealed the cross corridor door on Cottonwood Court operated at a very high speed. Maintenance manager confirmed the speed and commented	S 166	S 166: Facility maintenance director adjusted door closing speed on all neighborhoods to an acceptable and safe speed on 04/27/2022. IDT reviewed and revised the policies and procedures related to preventative maintenance on 05/18/2022. Facility maintenance director will provide a directed inservice for all staff on 06/08/2022 relating to the policies and procedures related to preventative maintenance. Facility maintenance director or designee will audit the door closing speeds once a month or as needed as a part of regular preventative maintenance duties. Audits will begin May of 2022. Facility maintenance director or designee will present the findings of the audit to the QAPI committee at their quarterly meetings for review and recommendation.	06/16/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack | TITLE: Administrator | (X6) DATE: 05/17/2022

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	10677-2	A. BUILDING: _____ B. WING _____	04/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

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S 166	Continued From page 1 the speed was to overcome the air pressure differences. After discussion regarding the previous survey, we walked to Plum Creek unit to test the cross corridor doors at the location. Speed of these doors was excessive as well. The speed may injure a frail person were the magnet to disengage. The door speed was not currently a part of the preventative maintenance program. This deficiency has the potential to affect all residents.	S 166		
S 169	44:73:02:18(5-7) Occupant Protection The facility shall take at least the following precautions: (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters shall be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors. Any other exterior doors shall be locked or alarmed. The alarm shall be audible at a designated staff station and may not automatically silence when the door is closed; (7) A portable space heater and portable halogen lamp, household-type electric blanket or household-type heating pad may not be used in a facility; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 29354 Based on observation and interview, the provider failed to ensure two of two front entrance doors (main door entrance to the long-term care and	S 169	S 169: Facility Maintenance director updated door alarm times to ensure doors are alarmed at all times 24 hours per day 7 days a week. IDT reviewed and revised policies and procedures related to door alarms on 05/13/2022. Administrator A or designee will hold a directed inservice for all staff on 06/08/2022 regarding new door alarm policies and procedures. Facility maintenance director or designee will audit door alarm times once a week for four weeks and once a month for 2 more months or for as long at the QAPI committee deems necessary. Facility maintenance director or designee will present the findings of the audit to the QAPI committee at the quarterly meeting for review and recommendation.	06/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 169	Continued From page 2 the assisted living center) had been alarmed, locked, or attended to at all times to ensure resident safety. Findings include: 1. Observation on 4/26/22 at 7:30 a.m. revealed: *There were two entrances leading into the building. -One entrance was identified as the long-term care and one entrance was identified as the assisted living. *The surveyor entered through the front entrance door leading into the assisted living area. -Upon entrance into the building, the door was not locked, there was no alarm sounded, or an attendant was present. -After the surveyor self-screened for COVID-19, she waited five minutes until a staff member approached her to ask if she needed assistance. Observation on 4/26/22 at 5:50 p.m. by the assisted living front door entrance revealed: *There was not an attendant present. *A sign on the door stated the door was locked between 5:00 p.m. and 8:00 a.m. *The surveyor pushed on the front entrance door and an alarm sounded. *Licensed practical nurse (LPN) L and assisted living administrator-in-training M came to the front door. Interview at that time with LPN L and assisted living administer-in-training M regarding the assisted living front door entrance revealed: *The front door was on a timer and locked at 5:00 p.m. and unlocked at 7:00 a.m. *There was an intercom system in the alcove of the doorway anyone could use to "buzz for assistance." *There were no cameras.	S 169		

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S 169	Continued From page 3 Observation on 4/27/22 at the following times revealed: *At 7:40 a.m.: -The assisted living front entrance door was unlocked, there was no alarm sounded, or an attendant was present. -No staff member had come to check the front door. *At 8:10 a.m. and 8:20 a.m: -The long-term care front entrance door was unlocked, there was no alarm sounded, or an attendant was present. Interview on 4/27/22 at 2:05 p.m. with administrator A regarding the long term care front entrance door and the assisted living front entrance door revealed: *Both doors were locked at 5:00 p.m. and unlocked at 7:00 a.m. -The doors did not alarm from 7:00 a.m. through 5:00 p.m. -There were no notifications sent out to staff if anyone had entered through those two doors. *There was an attendant at each doorway Monday through Friday. *There was not an attendant at each doorway on weekends and most holidays. *The doors were on a timer. -They did not "manually" get locked. *He was not aware of any resident elopements through either front door since he had been employed four and one-half years ago. *They did not have a Door Alarm policy. *He agreed there were times when the two doors had not been attended or not alarmed.	S 169		
S 236	44:73:04:12(1) Tuberculin Screening Requirements	S 236	S 236: Employees I, J, and K all received parental consent for TB testing and all received a TB test which was included in their employee files.	06/16/2022

South Dakota Department of Health

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S 236	Continued From page 4 Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and personnel file review, the provider failed to ensure three of five sampled employees (I, J, and K) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of employee I, J, and K's personnel record revealed:	S 236	Beginning 05/23/2022, DON or designee will review all employee health files to ensure that staff had a TB test record on file. Those staff members who did not have a test on file will be tested for TB. IDT reviewed and revised, as necessary, the policies and procedures related to TB testing on 05/18/2022. HR Director or designee will hold a directed inservice for employees I, J, and K and all staff on 06/08/2022 to provide education on the facility's policy and procedure related to TB testing. HR Recruiter or designee will audit all new employee files once a week for four weeks and monthly for two more months to ensure all new staff have the required TB test completed. Audits will begin on 05/23/2022. HR Recruiter or designee will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	

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S 236	Continued From page 5 *Employee I's date of hire was 2/14/22. *Employee J's date of hire was 2/10/22. *Employee K's date of hire was 3/10/22. *There was no record of any TB skin test or TB screening. Interview on 4/27/22 at 3:30 p.m. with director of nursing B revealed: *The provider had switched to using the QuantiFERON gold test. *That is a blood test. *Employees I, J, and K all required a parent or guardian approval for the test. *She had not received approvals for those employees. *She had reminded the employees many times. *She had not tried to contact the parent or guardians for the approval. *The above employees had been working with the residents during this time.	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 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 4/25/22 through 4/27/22. Bethany Home - Brandon was found not in compliance with the following requirement: S060.	S 000		
S 060	44:74:02:15(1-2) Nurse Aide Curriculum The curriculum of the nurse aide training program shall address the medical, psychosocial, physical, and environmental needs of the residents served by the nursing facility. Each unit of instruction shall include behaviorally stated objectives with	S 060	S 060: NA J was found to be a fully certified CNA on the SDBON website. Registery number A055301. NA I will taken off of the floor until they have completed the necessary training required. DON audited all employees currently listed as an NA to ensure they have completed the necessary training. If any were found to have not received this training, they were removed from direct resident contact until training is completed.	06/16/2022

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S 060	Continued From page 6 measurable performance criteria. The nurse aide training program shall consist of at least 75 hours of classroom and clinical instruction, including the following: (1) Sixteen hours of training in the following areas before the nurse aide has any direct contact with a resident; (a) Communication and interpersonal skills; (b) Infection control; (c) Safety/emergency procedures, including the Heimlich maneuver; (d) Promoting residents' independence; (e) Respecting residents' rights; and (f) Abuse, neglect, and misappropriation of resident property; (2) Sixteen hours of supervised practical training, with enough instructors to ensure that nursing care is provided with effective assistance and supervision. The ratio may not be less than one instructor for each eight students in the clinical setting; and This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to ensure the primary instructor provided sixteen hours of supervised practical training before two of two (I and J) nurse aides (NA) had any direct contact with a resident. Findings include: 1. Interview and record review on 4/27/22 at 3:30 p.m. with director of nursing (DON) B revealed: *NA I had been hired on 2/14/22. *NA J had been hired on 2/10/22. *Neither NA I nor J had completed the required sixteen hours of training prior to providing care too the residents. Both NA I and J had been	S 060	IDT reviewed as revised, as necessary, the policies and procedures relating to CNA training and orientation on 05/18/2022. DON B or designee will hold an all staff inservice on 06/08/2022 to educate staff on the policies and procedures related to CNA training and orientation. DON B or designee will audit that all NAs receive all of the required training elements before having direct resident contact starting 05/23/2022. Audits will be once a week for four weeks and once a month for two more months. DON B or designee will present the findings of the QAPI committee at their quarterly meeting for review and recommendation.	

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S 060	Continued From page 7 working with the residents since they had been hired. That training would have included: -Communication and interpersonal skills. -Infection control. -Safety/emergency procedures, including the Heimlich maneuver. -Promoting residents' independence. -Promoting residents' rights. -Abuse, neglect, and misappropriation of resident property. *The program coordinator was not available to be interviewed. *DON B thought the regular orientation training would have been enough. *NAs I and J had started the on-line education to become a certified nursing assistant. *NAs I and J had only completed a few modules of that training.	S 060		