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 _____	01/18/2024

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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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 1/16/24 through 1/18/24. Bethel Lutheran Home was found not in compliance with the following requirements: F625, F812 and F880.	F 000	STATEMENT OF COMPLIANCE: The following represents the plan of correction for alleged deficiencies cited during the survey that was conducted from 1/16/2024 through 1/18/2024. Please accept this plan of correction as Bethel Lutheran Homes Credible Allegation of Compliance with the completion date of 3/03/2024.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625	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. F625 {483.15(d)(1)(2)} Bethel's Bed Hold Policy will be revised and approved by the QAPI committee at the February meeting. Nursing and Social Services Designee work flows regarding resident transfers will now include notification of the OMBUDSMAN as well as ensuring POA is signing the Bed Hold agreement. All RN/LPNs will be re-educated on the New Bed Hold Policy by 03 March 2024.	03 Mar 24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremiah Schneider — TITLE: Administrator/CEO — (X6) DATE: 05 Feb 2024

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 625	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, and policy review the provider failed to ensure resident and/or their representative received a written notification with information regarding a transfer to the hospital and was provided a copy of the transfer notice to the Office of the State Long-Term Care Ombudsman for one of one sampled resident (42) that was reviewed for facility-initiated hospital transfers. Findings include: 1. Review of resident 42's electronic medical record (EMR) revealed: *She was complaining of chest pain in the dining room on 12/6/23. *A standing order for Mylanta 15 mL was given at 12:30 p.m. *She was transported to her room. *Her vital signs were: -Temperature 97.3. -Blood pressure 171/91. -Respirations 26 -Oxygen 93% room air. *She was given an Albuterol nebulizer treatment per physician's order. *After nebulizer treatment she stated, "Something is wrong, and I need to go to the hospital now." *Her son was called and agreed resident should go to the emergency room. *She was admitted to the local hospital for further evaluation. *She returned to the facility on 12/8/23. Further review of the EMR and paper chart revealed there was no written notification to the resident or her responsible party regarding the Bed Hold policy and no notification to the Ombudsman that resident 42 had been sent and	F 625		

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F 625	Continued From page 2 admitted to the hospital. Interview on 1/18/24 at 9:48 a.m. with social service designee (SSD) K revealed: *She reviewed the bed hold policy with residents and their representatives upon admission. *The charge nurse would notify the family and complete the bed hold form when a resident was transferred to the hospital. *She could not find a signed bed hold for resident 42's 12/6/23 hospital transfer. *She was not aware the Ombudsman needed to be notified for hospital transfers when residents were admitted. Interview on 1/18/24 at 10:18 a.m. with director of nursing B revealed: *It was her expectation that the bed hold would be signed for all hospital transfers. *She confirmed a bed hold was not signed when resident 42 went to the hospital. *A verbal notification was given to the family over the phone. Review of the provider's undated Bed Hold Policy and Notification revealed: *"It is our policy to inform residents/legal representatives upon admission and after leaving the facility for hospitalization, observation or therapeutic leave of our Bed Hold Policy and Notification. *Each resident/legal representative will be informed by a (provider) staff of the facility's Bed Hold Policy and Notification upon admission to the facility and/or when a resident leaves for hospitalization, observation or therapeutic leave."	F 625		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 3 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review the provider failed to maintain sanitary conditions in the kitchen and to ensure foods were stored, handled, prepared and served in a safe and sanitary manner for the following: *Appropriate glove use and hand hygiene for one of one cook (D) while preparing and serving food. *Appropriate glove use and hand hygiene for two of two dietary aides (G and H) while handling food. *Appropriate glove use and hand hygiene for one of one cook assistant/dietary aide (L) while serving food. Findings include: 1. Initial kitchen tour on 1/16/24 at 3:41 p.m. revealed:	F 812	F812 {483.60(i)(1)(2) The Dietary Manager disposed of the expired Orchard Splash prune juice immediately when identified during the survey. Boxes of food items were placed on shelves and staff were instructed to keep all food items off the floor in refrigerated/frozen and dry storage areas. Alcohol pads were obtained and placed in areas where food thermometers are kept, staff were immediately educated on proper use of cleaning food thermometers. A Dietary Staff in-service will be held on February 16, 2024, on Food Safety and Sanitation for all Dietary Staff. The Dietary Manager (DM) and/or a designee will complete glove use, hand hygiene, thermometer and hairnet use audits twice weekly for three months and then monthly for the next year. The Dietary Manager will report her findings monthly at the facility's Quarterly Assurance (QAPI) meeting and will be reviewed by the QAPI team. The Registered Dietitian (RD) will perform monthly sanitation audits. The audits will include proper glove use, hand washing, and proper food storage. The RD will report her findings monthly at the facility's monthly Quality Assurance (QAPI) meeting by the DM or RD and reviewed by the QAPI team.	03 Mar 24

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F 812	Continued From page 4 *One container of Orchard Splash prune juice with an expiration date of 10/12/23 was open, and in the refrigerator *Two boxes of food items (hoagie buns and garlic toast) was sitting on the floor of the walk-in freezer. *Cook D put on gloves, placed those gloved hands on a wheeled garbage can and moved it, then begun slicing strawberries with those same gloves on. *Cook D then walked over to the stovetop, stirred a food item in a pot, returned and continued to cut the strawberries, all with those same gloved hands. *Cook D walked about the kitchen, touching several surfaces including counters, papers (hanging on cupboard doors/cork boards/clipboards) and drawers without removing his gloves, washing hands or putting on new gloves and again returned to cutting the strawberries. Observation and interview on 1/16/24 at 5:10 p.m. through 5:24 p.m. with cook D during evening meal prep & service revealed he: *Stated he had been working as a cook for about a year. *Had gloves on both hands, placed an oven mitt over his gloved left hand and checked on a trayed food item in the oven. *Then closed the oven door and removed the oven mitt from his left hand, leaving his gloves in place. *Moved to a two-sectioned sink and filled a large pot with water with those same gloved hands. *Continued to use those oven mitts with the same gloves on while stirring the food item on the stove. *Continued to move throughout the kitchen while	F 812		

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F 812	Continued From page 5 he touched multiple surfaces and placed pans in the food warmer with those same gloved hands. *Obtained temperatures of the carrots, chowder, pie filling, pot pies and used the same towel to wipe the temperature probe between each food item that was probed. *Had the same gloves on throughout the entire observation period. 2. Observation on 1/16/24 at 5:19 p.m. through 5:29 p.m. of dietary aide G revealed she: *Went in and out of the kitchen without washing her hands or putting on gloves and removed items from the refrigerator. *Was not wearing a hairnet, but her hair was styled in a single braid. *Walked in and out of the walk-in cooler and delivered food items to the dining room without gloves or washing her hands. 3. Observation on 1/16/24 at 5:20 p.m. through 5:29 p.m. of dietary aide H revealed he: *Entered the kitchen and had not washed his hands or put on gloves. *Entered the walk-in cooler/freezer area and exited with a tub, placed it on the counter and placed jugs of milk in it, then exited the kitchen. *Again entered the kitchen without washing his hands or putting on gloves. *Entered the walk-in cooler/freezer area and delivered a metal tub containing what appeared to have been individual containers of ice cream to a counter behind the food service area and exited the kitchen. 4. Observation on 1/16/24 at 5:33 p.m. through 5:45 p.m. of Cook D while plating and serving food revealed he: *Held a slice of bread in his previously gloved left	F 812		

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F 812	Continued From page 6 hand, added egg salad on it and placed another slice of bread on top of it to make a sandwich. *Placed the sandwich on a cutting board, cut it, placed it on a plate, filled a soup bowl with chowder and placed the bowl on the plate with the same gloved hands. *Then rested his gloved hand on his apron (right hip area), rested the gloved hand on top of plate and used that plate to assemble another sandwich in the same manner as stated above. *Wiped food off his gloved left hand with the towel that was used to wipe off the food thermometer probe. *Wiped his nose then his face with his right gloved hand and proceeded to plate the resident's food and served it. Interview on 1/16/24 at 5:51 p.m. with cook D regarding food temping process, glove use and hand hygiene revealed he: *At that time removed his gloves, washed his hands and put on a new pair of gloves. *Stated he used the sanitizer, walked to the wall-mounted sanitizer jug, pointed to it (jug is tabled as J-512) and stated "Now it's just a dirty rag." *Then stated he usually used alcohol pads to clean the thermometer probes but they were out and was not aware where alcohol pads were located. *He stated that he would change his gloves when he was done with a task and moved on to another task. 5. Observation on 1/17/24 from 8:15 a.m. through 8:33 a.m. of cook assistant/dietary aide L while plating and serving resident's food in the kitchen revealed she: *Coughed into her left elbow/arm bend and did	F 812		

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F 812	Continued From page 7 not wash her hands or change her gloves. *Continued to plate and serve resident's food. *Then stated her gloves were too big, discarded those gloves and put on a new pair of gloves without washing her hands. *Picked up toast from a tray with those gloved hands, placed toast on a plate and served it. *She continued to use those same gloved hands throughout the remainder of the observed breakfast food service. 6. Observation and interview on 1/17/24 at 8:27 a.m. of the walk-in freezer with dietary manager F revealed: *Four boxes of food items stored on the freezer floor, identified as: doughnuts, cinnamon rolls, hoagie buns, and garlic toast. *She stated that those items should not have been placed on the floor. 7. Observation on 1/17/24 11:30 a.m. of cook assistant/dietary aide L revealed: *While plating resident food items, she turned around and sneezed into her left elbow/arm bend area. *She had not washed her hands or changed her gloves. *She continued to plate and serve resident food, sneezed again without performing hand hygiene or changing her gloves. 8. Interview on 1/18/24 at 8:09 AM with dietary manager F regarding the above observations regarding food storage, food handling, expired foods, glove use, hand hygiene and kitchen sanitization revealed her expectations would have been for the following: *Staff should wash their hands when entering the kitchen.	F 812		

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F 812	Continued From page 8 *Gloves and an apron should have been worn by staff when handling food. *Staff should wash their hands and put on a new pair of gloves after coughing or sneezing. *Staff should use alcohol probe wipes between each food item when taking temperatures. *No food items in boxes should have been placed on the floor in the freezer. 9. Review of the provider's January 2024 Glove Use When Preparing/Serving Food policy revealed: *Gloves must be worn when handling ready to eat food directly. Tongs/Utensils may be used instead of gloves when serving/preparing ready to eat foods. *Gloves may become contaminated and/or soiled and must be changed between tasks. *Disposable gloves were single-use items and should be discarded after each use. *Hands should have been washed before glove use. Review of the provider's updated January 2024 Food Preparation and Service policy revealed: *Food preparation staff would adhere to proper hygiene and sanitary practices to prevent the spread of food borne illnesses. *Dietary services staff and other staff that assist with meal service should wash their hands before serving food to residents. Handwashing will also occur after collecting soiled plates and food waste prior to handling food trays. *Bare hand contact with ready to eat food was prohibited. *Staff that entered the kitchen should wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not come in contact with the food.	F 812		

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F 812	Continued From page 9 Review of the provider's updated January 2024 Food Handling - Preventing Foodborne Illness policy revealed: *Critical factors implicated in Foodborne illness are: Poor personal hygiene of dietary staff...contaminated equipment. *All employees who handle, prepare or serve food would be trained in the practices of safe food handling and preventing food borne illness. Employees will demonstrate knowledge and competency in those practices prior to working with food or serving food to the residents. *All food service equipment and utensils would be sanitized according to manufacturer's recommendations. Review of the provider's 10/27/2017 Food Storage policy revealed: *Food was stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination. *Food should have been stored off of the floor.	F 812		
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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		

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F 880	Continued From page 10 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 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.	F 880	Directed Plan of Correction Bethel Home Lutheran Home, Madison F880 Corrective Action: 1. For the identification of lack of appropriate: *Maintenance and use as well as disposal of personal protective equipment by staff following entrance to resident rooms who were on transmission-based precautions. *Signage for the type of isolation precautions. *Labeling and storage of resident's personal care items in bathing rooms. *Cleaning and maintenance in bathing room to prevent buildup of residue and dust. The administrator, DON, infection control nurse and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. Please do read 2567 findings All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 29 February 2024, by IP RN, DON, Administrator or Designee Identification of Others: 2. Individual residents and other residents as well as staff have potential to be impacted when inconsistent infection control practices by all facility staff are done. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by date by IP RN, DON, Administrator or Designee.	03 Mar 24

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F 880	Continued From page 11 §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: Based on observation, interview, and policy review, the provider failed to ensure the following: *Appropriate use, storage, and disposal of personal protective equipment (PPE) by three of three registered nurses (RNs) (E, I, and J) after entering two of two sampled resident's (2 and 7) rooms who were on transmission-based precautions (TBP) for influenza A and COVID-19. *Signage for the type of isolation precautions required for two of two sampled residents (2 and 7). *Storage and labeling of resident's personal care items in one of one bathtub rooms. *Cleanliness was maintained in one of one bathtub room to prevent the buildup of residue and dust. Findings include: 1. Observation and interview on 1/16/24 at 4:16 p.m. with RN I outside resident 2's room revealed: *She was wearing a gown, mask, and gloves when she exited the room. *There was no signage on the resident's door to	F 880	System Changes: 3. Root cause analysis conducted answered the 5 Whys: We will no longer be re-using N95 Masks as there is no longer a shortage which will address the Root Cause of the F880 Tag. We need to re-educate staff on proper Signage as this is not effectively covered in our education. We need to continually re-enforce IP practices on IP, Donning/Doffing, Mask storage. Need clearer definition of roles/responsibilities concerning IP Practices. Re-educate and re-enforce staff that IP is EVERYONE's job not just the IP RN. Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education /training with demonstrated competency and documentation. Administrator contacted the South Dakota Quality Improvement Organization (QIO) on 31 January 2024 and include Per our conversation, you stated you have a good understanding of the RCA process and have begun mitigation steps such as re-education, increased monitoring, having correct infection precaution signage available and getting rid of the practice of conserving N95 masks in brown paper bags since PPE supply should not be an issue anymore. Having defined roles and responsibilities such as who is cleaning the med cart every shift, cleaning and maintaining the bath/shower. room in good condition with special attention to ensuring personal items are labeled and separate is a suggestion. Personal items should not be touching other people's personal items.	

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	435076	A. BUILDING _____ B. WING _____	01/18/2024

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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F 880	Continued From page 12 indicate she was on TBP. *There was a PPE cart in the hallway to the right of resident 2's room and there were two laundry hampers a few steps away to the left of her room. *There was a blue rectangular sign on the upper right-hand door frame that read "wash your hands." *Resident 2 had influenza A. *She stated, "The resident would be on droplet precautions, which goes along with contact precautions." *When asked how a visitor might know if the resident was on TBP and what PPE to wear, RN I went back into the resident's room and came back out with a sign. -She indicated that the sign "was on the inside of the door." -She proceeded to post the sign on the exterior of the door. *The sign indicated the five steps of donning PPE. The sign did not indicate what type of PPE was required to enter that room. 2. Observation on 1/17/24 at 9:03 a.m. through 9:15 a.m. with RN J revealed: *She was outside of resident 2's room with the medication cart. *There were now two signs on the resident's door. *The signage indicated the five steps of donning PPE and "how to hand rub" that explained how to appropriately use hand sanitizer. *There was still no signage to indicate what type of PPE was required to enter the resident's room. *She removed a brown paper bag from the medication cart, removed a used N95 mask from the bag, and placed it directly on the medication cart. -She then placed the N95 mask back into the	F 880	Monitoring: 4. Administrator, DON, and/or designee wil conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 13 bag. -She had not sanitized the medication cart after placing the potentially contaminated N95 mask directly on the cart. *Without performing hand hygiene, she donned a gown, a surgical mask, and gloves before entering resident 2's room. *She came out of the room with her PPE still on. She had not removed or discarded the contaminated PPE in the resident's room. *With the contaminated gloved hands, she touched the door handle to close the resident's door. *She then removed her gloves, gown, and mask. -She walked to the laundry hampers a short way down the hall to place the soiled PPE inside the hamper. *After performing hand hygiene, she placed the resident medication cards on the potentially contaminated medication cart. *She prepared the resident's medications and donned the PPE without performing hand hygiene. *She knocked on the resident's door, touched the contaminated door handle with her contaminated gloves, and entered the resident's room. 3. Observation of the PPE supply dresser that was located by resident 7's door revealed: *It contained opened N95 masks in paper bags in the second drawer. *The bags were open on the end without folding or closure of any kind. *Some bags had names on them, some had not had names on them. . *No cleaning or disinfecting supplies on it or in it. 4. Interview on 1/17/24 09:15 am with the director of nursing (DON) B revealed:	F 880		

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F 880	Continued From page 14 *Resident 7 was COVID-19 positive. *Her isolation window was anticipated to end on 1/23/24 or 1/24/24. *Visitors were able to go into her room directly and back out with the proper use of PPE. *All visitor's information was posted at the front entrance to wash hands, not come in if sick, etc. *They did send out a notice to all the families and staff that there was a positive in the building. 5. Interview on 1/17/24 at 9:25 am with licensed practical nurse/infection preventionist (LPN/IP) C regarding PPE for COVID outbreaks revealed: *Resident 7 was positive last week. *They do not require masking for one isolated case, but would if there was more than one positive COVID case, and that was what their policy indicated. *She stated they follow the CDC guidelines so when that changes, they change their policy. 6. Observation and interview on 1/17/24 at 9:57 am with LPN/IP C regarding resident 7's door signage and the PPE supply dresser revealed: *She was not able to state what type of precautions the resident was on. *There was no signage on the door that identified the type of PPE required. *There was a sign on the door the stated "BEFORE ENTERING EVERYONE MUST: *gown *gloves *mask *goggles." *She stated that since they had enough supply, staff wore N95s and stored in paper bags. *The paper bags were again noted to have been opened at the end. *LPN/IP C turned one bag top over and shut the drawer. *LPN/IP C stated staff wear the N95 mask during their shift and then would get a new N95 mask	F 880		

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F 880	Continued From page 15 and a new paper bag at the beginning of their next scheduled shift. 7. Observation of LPN/IC on 1/17/24 at 10:44 am revealed: *She stated she had previously stated the wrong precaution type, that it [COVID] was a step above, which was airborne. *She then placed an airborne precautions sign on resident 7's door. 8. Observation on 1/17/24 at 1:14 p.m. of the bathtub room across from the chapel revealed the following items were improperly stored and labeled per the provider's policy: *There was an electric razor stored in a three-drawer plastic storage tower with other resident's personal hygiene products such as nail files, nail clippers, and combs. -The electric razor appeared clean on the outside but inside the razor head, there was a significant amount of hair. *There was an opened package of rolled bandages labeled "[resident name] leg 3rd" in the above-mentioned storage tower. *There were three open cardboard boxes of bar soap labeled with resident information stored on top of the tub. *There were approximately 55 personal care products (assorted shampoos, soaps, lotions, and body sprays) on two shelves in the wooden cabinet. Only 11 out of the approximately 55 containers were labeled with the resident's information. *10 out of the 16 pieces of paper in the tub room were not laminated or in page protectors, that meant those papers were not a cleanable surface. *There was a cloth bag hung on the arm support	F 880		

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F 880	Continued From page 16 of the tub seat that was visibly soiled with an unidentifiable white residue. *There was an open white N95 mask hanging from the glove box holder on the back wall. *There was significant dust on top of the tub, on the radio on the windowsill, and on the oxygen concentrator. 9. Interview on 1/17/24 at 1:26 p.m. with housekeeper M about cleaning the bathtub room revealed: *Housekeeping was responsible for cleaning the bathtub room. *She did not know how often the bathtub room should have been cleaned. 10. Observation on 1/17/24 at 2:10 p.m. of the PPE supply cart located near resident 7's room revealed: *One unwrapped N95 mask on top of the PPE dresser and one opened paper bag containing one unwrapped N95 with no name on the bag. *LPN/IP C discarded the N95 on top of the PPE dresser without using gloves or performing hand hygiene. *LPN/IP C discarded the paper bag containing the used N95 without using gloves or performing hand hygiene. 11. Observation on 1/17/24 at 2:16 p.m. of RN E revealed she: *Had walked down the hallway with goggles and an N95 mask on her face and then stopped at the PPE dresser by resident 7's room. *Put on a gown and gloves and then entered resident 7's room with a medication cup in her hand and shut the door. *Opened the door and was noted to have removed and discarded the gloves and gown	F 880		

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F 880	Continued From page 17 inside the resident's room. *Exited the resident's room with the same goggles and N95 on her face. *Continued to walk down the hallway with those goggles and N95 on her face. *Then stood at the nurse's station, removed the goggles and the N95, and then placed them in a paper bag. 12. Interview and observation on 1/17/24 at 2:46 p.m. of the nurse's station with LPN/IP C regarding the above observation of RN E revealed: *She had not seen RN with her goggles and N95 mask on. *She found RN E's goggles and N95 mask in a paper bag with her name on it in a cupboard at the nurse's station. *There were other paper bags in that cupboard. *She confirmed that not removing the goggle and the N95 mask at the resident's room and walking down the hallway with those items on was not acceptable practice following entry into a COVID-positive resident's room. 13. Interview on 1/17/24 at 3:15 p.m. with housekeeping manager N regarding the bathtub room revealed: *When asked who cleaned the bathtub room she stated, "They [nursing staff] said they were cleaning it, but I should have checked." *She stated that the certified nurse aides (CNAs) cleaned the bathtub, and she cleaned the room. 14. Interview on 1/18/24 at 11:19 a.m. with LPN/IP C about the above observations revealed: *There was no medication cart cleaning policy. *She expected the medication cart to have been	F 880		

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F 880	Continued From page 18 cleaned and disinfected every day at the end of the shift. *She confirmed that RN J should have cleaned and sanitized the medication cart after she set the potentially contaminated N95 mask onto the cart. *She agreed there were missed hand hygiene opportunities. *She stated that staff were educated on the donning and doffing of PPE. 15. Interview on 1/18/24 at 1:37 p.m. with LPN/IP C, DON B and administrator A regarding the above observations revealed LPN/IP C would expect: *Staff to take off the gown and gloves inside the resident's room, then exit the room, remove the goggles or face shield and mask, put it in the brown paper bag, close the paper bag, put the paper bag in the second drawer of the dresser. *Hand hygiene should have been performed prior to before putting on PPE and after removing PPE. *Staff should have sanitized their hands before removing protective eyewear and N95 masks and before closing the brown paper bag to avoid contamination. *She agreed that the staff observations confirmed the staff had not followed the expected processes for infection prevention. *She stated staff have been educated on infection control and PPE use, and again in December 2023. 16. Interview on 1/18/24 at 3:05 p.m. with LPN/IP C about her expectations for TBP signage and bathtub room cleanliness revealed: *Signage should have been posted on the resident doors who were on TBP. -The signage should have specifically stated which type of TBP was required (contact, droplet,	F 880		

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F 880	Continued From page 19 or airborne). *The facility used a text message/call system to alert all staff and families of TBPs. *Her expectation was that all razors were labeled and stored in the resident's room. *When asked if razors were shared, she stated, "they all have their own." -She explained that razors were provided to any resident that did not have one. *Her expectation was that all resident's personal products in the cupboard should have been labeled. 17. Review of resident 2's electronic medical record revealed she was diagnosed with influenza A on 1/12/24. 18. Review of the provider's "Policy & Procedure: Isolation - Initiating Transmission - Based Precautions" revised December 2018 revealed: *"Policy Statement - Transmission-Based Precautions will be initiated when there is reason to believe that a resident has a communicable infectious disease. Transmission-Based Precautions may include Contact Precautions. Droplet Precautions, or Airborne Precautions." *"Policy Interpretation an Implementation-" -"5. When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee) shall:" --"a. Ensure that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained near the resident's room so that everyone entering the room can access what they need." --"b. Post the appropriate notice on the room entrance door so that all personnel will be aware of precautions, or be aware that they must first see a nurse to obtain additional information about the situation before entering the room".	F 880		

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F 880	Continued From page 20 --"c. Ensure that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room;" Review of the provider's "Isolation - Categories of Transmission-Based Precautions" policy reviewed on 5/6/20 revealed: *"Policy Statement: 1..... Transmission-based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others." *"Droplet Precautions" -"7. Signs- The facility will implement a system to alert staff to the type of precaution resident requires." --"a. The facility utilizes the following system for identification of Contact Precautions for staff and visitors: Sign on the door." *"Precautions for Coronavirus:" -"1. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment." -"2. Implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets." -"5. Mask with eye protection" --"a. Put on a mask with eye protection when entering the room." Review of the provider's February 2014 "Storage of Resident Personal Care Items" policy revealed: *"Policy"	F 880		

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F 880	Continued From page 21 -"Resident personal care items are stored in a manner that discourages cross contamination and/loss of items." *"Procedure" -"a. Resident personal care items including, but not limited to, hair combs, brushes, picks, tooth/denture brushes, denture cups, colognes, body sprays, powders shall be labeled with the resident's name or initials using a black permanent marker or a label machine if they are stored in the resident's bathroom. The items do not require labeling if they are stored in the resident's room." -"b. Personal care items are stored on the shelved areas of their closets in their room or in a drawer unit in the residence bathroom. Depending on the residence preference." -"c. The shelves of the closet are labeled to allow individualizes grouping of oral hygiene, personal care & hair/care items." -"d. If a drawer unit in the bathroom is utilized, the appropriate drawers are labeled with the resident's name using the label machine." Review of the provider's November 2018 "Policy & Procedure: SHAVER CLEANING" revealed: *"Procedure:" -"5. Brush any whiskers into the trash using shaver brush." -"6. Release shaver heads from holder." -"7. Wash shaver heads with warm soapy water..." -"15. Replace shaver in the proper place (resident room or utility room)."	F 880		

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

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E 000	Initial Comments An emergency preparedness survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 1/16/24 through 1/18/24. Bethel Lutheran Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremiah Schneider
TITLE: Administrator/CEO
(X6) DATE: 05 Feb 2024

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/17/24. 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 the deficiency identified at K920 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 1/16/2024 through 1/18/2024. Please accept this plan of correction as Bethel Lutheran Homes Credible Allegation of Compliance with the completion date of 29 March 2024. 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.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of	K 920	K920 Residents residing in the facility have the potential to be affected in the similar manner. The Bath Aide, CNAs, and Nurses will be re-educated on policy concerning utilization of Power Cords, and extension cords. This education will be conducted by the DON or designee by 29 March 2024. Maintenance staff and/or Nursing staff will complete a daily check on the tub room for 30 days and weekly for 2 months to ensure proper compliance with policy.	02 Mar 24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.

Jeremiah Schneider Administrator/CEO 05 Feb 2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/17/2024**

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
K 920	Continued From page 1 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain electrical safety within one of one whirlpool room. The provider must comply with the Healthcare Facilities Code (NFPA 99), and the Life Safety Code (NFPA 101). Findings include: 1. Observation on 1/17/24 at 2:30 p.m. revealed the electric lift for the whirlpool spa and a vital sign monitoring machine were plugged into an electrical plug strip. Also plugged into that same strip was a radio and an extension cord. Personal electronics may not be plugged into a plug strip. Extension cords may not be used as a substitute for permanent wiring. Interview with the plant operations manager at 3:15 p.m. after the above observation confirmed that finding.	K 920	QAPI Committee will add this to the monthly QAPI agenda for 3 months to ensure compliance.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10644	A. BUILDING: _____ B. WING _____	01/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/16/24 through 1/18/24. Bethel Lutheran Homes 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 1/16/24 through 1/18/24. Bethal Lutheran Homes was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jeremiah Schneider — TITLE: Administrator/CEO — (X6) DATE: 05 Feb 2024