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	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda of Beresford	606 W Cedar Beresford, SD 57004

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facilityˆreported incident (FRI) review, interviews, record review, and policy review, the facility failed to ensure the implementation of policies and procedures for conducting neurological assessments following unwitnessed falls or potential head injuries for three of six sampled residents (1, 2, and 3). Findings Include:1. Review of the provider's 3/3/26 SD DOH FRI revealed on 3/2/26 at 3:35 p.m., resident 1 was found on his fall mattress (padded mat placed directly on the floor) next to his bed by licensed practical nurse (LPN) D. While assessing resident 1, LPN D and CNA G identified that resident 1's oxygen concentrator (a device that filters room air into purified oxygen) was turned off, although his nasal cannula (NC) tubing (flexible tubing that delivers oxygen through the nose) was on the resident and attached to the concentrator. Resident 1 had a physician's order to receive oxygen continuously at a rate of 3 liters (L) per minute. His oxygen saturation was 60% when he was found on the floor and increased to 93% when his concentrator was turned on. Resident 1 did not get up for supper on 3/2/26 due to drowsiness.CNA G informed administrator A during resident 1's fall investigation that CNA I assisted resident 1 to bed at 1:40 p.m. after lunch. The CNAs were only responsible for turning oxygen concentrators and portable tanks on and off. Resident 1 was unable to do that due to vascular dementia (a form of cognitive decline caused by reduced or blocked blood flow to the brain, often from strokes or small vessel damage). He was last observed in bed at 3:15 p.m. by LPN D before being found on the floor at 3:35 p.m. CNA G reported seeing resident 1 in bed sleeping multiple times between 2:00 p.m. and the time of the fall. CNA I stated she did not know if she turned resident 1's concentrator on. On 3/3/26 at 8:30 a.m., Administrator A and Minimum Data Set (MDS) coordinator C started an investigation into the fall and concerns of neglect based on the fall report. CNA I's employment was suspended pending the investigation, and she left the faciity on 3/3/26.At 10:10 a.m. on 3/3/26, physician's assistant (PA) J evaluated resident 1 with his power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) present, and ordered that the resident to be transferred to the emergency department (ED) for assessment of increased oxygen needs, possible aspiration (when swallowing instead of a substance going down the esophagus into the stomach, the substance goes down the windpipe and into the lungs), and postˆfall evaluation. Resident 1 was transferred to the ED at 11:50 a.m. and returned to the facility at 4:50 p.m. The ED evaluation indicated resident 1's troponin (a heart-specific protein in the blood) was elevated, and intravenous (IV) fluids were administered.Documentation with an undated list of staff who received education on oxygen-related neglect. Audits were completed from 4/17/26 through 5/27/26, checking if resident 1 and all other residents on continuous oxygen were wearing their oxygen appropriately and as ordered. The audits indicated that the residents reviewed were wearing their oxygen as ordered.2. Review of resident 1's electronic medical record (EMR) indicated he admitted to the facility on [DATE]. His 3/17/26 Brief Interview for Mental Status (BIMS) was 0, which indicated his cognition was severely impaired. He had a diagnosis of obstructive sleep apnea (chronic disorder where the upper airway repeatedly collapses during sleep, blocking airflow), alzheimer's disease (irreversible brain disorder that destroys memory, and thinking skills),dementia (decline in cognitive abilities), acute and chronic (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respiratory failure with hypoxia (underlying, long term breathing disorder suddenly worsens, causing dangerously low oxygen levels in the blood), emphysema (progressive, irreversible lung disease where the tiny air sacs in the lungs are gradually destroyed), chronic obstructive pulmonary disease (lung disease that blocks airflow), peripheral vascular disease (narrowed or blocked blood vessels outside the heart and brain), congestive heart failure (the heart muscle becomes too weak to pump blood), and myocardial infarction (heart muscle is severely restricted or completely blocked).His undated care plan indicated on 8/26/23, the facility initiated that resident 1 has COPD and chronic respiratory failure. He was dependent on supplemental oxygen. He would remain free of secondary complications. There was no documented oxygen liter flow or amount of oxygen for resident 1 in his care plan.His 3/17/26 fall risk evaluation score was 15, which indicated he had a high risk for falling.His 3/2/26 neurological assessments were not completed by LPN D at 3:35 p.m., 3:50 p.m., 6:00 p.m., 6:30 p.m., and 7:00 p.m. because the resident was sleeping. At 4:05 p.m. and 4:20 p.m., the assessments were not completed because the resident was drowsy.His 3/3/26 through3/5/26 neurological assessments indicated that three of the six assessments were not completed due to resident 1 sleeping.His 3/2/26 progress note, completed by LPN D, indicated that the primary care physician (PCP) would evaluate resident 1 on 3/3/26 during the physician rounds. No documentation indicated that the PCP was called or faxed regarding resident 1's fall on 3/2/26. There was no documentation of the resident 1 going to the emergency department on 3/2/26.3. Review of the investigation of resident 1's fall on 3/2/26 indicated that the administrator discussed the fall with CNAs G and I, and LPN D on the evening of 3/2/26 to confirm their interactions with resident 1. None of those three staff members noticed if the oxygen concentrator was turned on for resident 1 when he was lying in bed until 3:35 p.m., when LPN D went in to give him his medications and found him lying on the floor. His POA was notified of his fall and current condition at 7:40 p.m. There was no documentation that the resident 1's PCP was notified of his falling incident on 3/2/26.4. Review of resident 2's EMR indicated that he admitted to the facility on [DATE]. His 4/16/26 BIMS score was 5, which indicated his cognition was severely impaired. His diagnoses included unspecified dementia a group of symptoms affecting memory, thinking, and social abilities), cognitive communication deficit, generalized muscle weakness, unsteadiness on his feet, and a history of falling. His 4/16/26 fall risk evaluation score was 10, indicating he had a high risk for falling.Resident 2's undated care plan showed that on 4/29/26, an intervention was initiated for staff to supervise the resident when he was walking due to his impulsivity and fast pacing. He resisted handsˆon assistance, did not use his call light to alert the staff when he needed the staff's assistance, and often refused staff assistance, including help with using the bathroom. The staff educated him, his family, and his caregivers about what to do if a fall occurs, ensured grip strips (adhesive strips that are added to the flooring to increase friction), adequate lighting in his room, monitored his balance and gait (walking), and provided reminders to him to slow down. He worked with therapy but did not show improvement due to his cognitive deficits.His care plan was updated to include additional interventions on 5/1/26 after he had a fall, directing resident 2 to wear nonˆskid socks at night. The staff removed his bathroom door to improve access and provided grab bars on both sides of the toilet. Because he was not used to using a walker, he would walk without it, and the staff had to assist him in finding a safe place to sit while they retrieved it. He needed the staff's support due to poor balance, but he resisted handsˆon assistance or a gait belt and became upset when he was touched. He moved quickly, remained at risk for falling, and required frequent reminders to slow down.On 5/5/26, an intervention was added to his care plan after he fell, that he liked placing his personal belongings in his walker. The staff was to direct him to his walker when he was without it. No additional fallˆprevention interventions were initiated after 5/5/26.The facility's fall incident reports indicated that after 5/5/26, resident 2 had thirteen additional falls in May 2026 and seven falls from June 1 through June 9, 2026. Since his admission on [DATE], he has had a total of twenty-seven falls. Fifteen of the falls were unwitnessed. Eight of those unwitnessed falls had neurological assessments initiated. Six of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the eight neurological assessments were not completed with the required neurological assessment components (level of consciousness, pupil response, motor function, including hand grasps and extremity movement, pain response, full vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), and observations) on the flow sheet within the required timeframe.After he fell on 6/9/26, the staff sent him to the emergency department due to a decreased level of consciousness. The neurological assessment flow sheet indicated his drowsiness began at 11:25 a.m. and continued until 12:40 p.m. His neurological assessments were completed every 15 minutes two times and every 30 minutes two times before he was sent to the ED.5. Review of resident 3's EMR revealed she admitted to the facility on [DATE] with a BIMS score of 8, which indicated her cognition was moderately impaired.Her diagnoses included Alzheimer's disease, dementia, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and depression. Her 5/7/26 fallˆrisk score was 13, indicating she was at risk for falling.Her undated care plan indicated that on 2/17/26, an intervention for the staff to anticipate her needs and remind her to use the call light was added. The staff educated her, her family, and caregivers on safety measures and fall response. They encouraged her to wear nonˆskid footwear, ensured her call light was within her reach, and maintained a bathroom light at night per her preference. They assisted her in turning the light back on if she shut it off.On 5/14/26, the facility added interventions because she did not consistently use her assistive devices. Her balance was sometimes poor, though she could step sideways or backward to correct herself.On 6/11/26 at 8:20 a.m., the care plan did not indicate that additional interventions were added after she fell and returned to the facility from the hospital.Progress notes from 6/5/26 at 12:35 p.m. revealed she had hit her chin and reported pain in her right shoulder and left wrist. At 9:37 p.m., she was admitted to the hospital for pneumonia, was administered oxygen and IV antibiotics, and had a right humerus fracture.Her 6/5/26 neurological assessment flow sheet was initiated after the fall; however, the flow sheet did not show documentation of a full neurological assessment before the staff sent her to the emergency department.6. Interview on 6/10/26 at 2:10 p.m. with MDS coordinator C revealed she was not able to recall the incident with resident 1 on 3/2/26 in detail. She directed the surveyors to refer to resident 1's incident documentation.7. Interview on 6/10/26 at 2:33 p.m. with CNA G revealed she observed the residents as she made her rounds in the hallway, and resident 1 was lying in bed each time she passed his room. She received a call over the walkie that a nurse needed assistance in resident 1's room. When she entered resident 1's room, the resident was on the fall mat on the floor, and the nurse was taking resident 1's vitals.8. Interview on 6/10/26 at 2:54 p.m. with LPN D revealed she was the nurse assigned to care for resident 1 on 3/2/26. She passed by resident 1's room while completing her 2:00 p.m. medication pass and noticed he was sleeping. His nasal cannula was in place with the plastic prongs inserted into each nostril and the tubing placed over the top of each ear, and his fall mat was by his bed, and his positioning pillows were in place. When she returned to his room for his scheduled medications and snacks, he was on his fall mat on the floor next to his bed. His oxygen level was low, but she could not recall the exact percentage. She and CNA G then realized the oxygen concentrator was not turned on.LPN D assessed him and initiated neurological assessments.9. Interview on 6/11/26 at 9:28 a.m. with CNAE revealed that the care plan can be reviewed to know what rate a resident's oxygen concentrator was to be set at. She indicated that the administrator or the nurses will tell the CNAs what the resident's oxygen setting should be. She indicated that the CNAs do not adjust the concentrators or regulators on the portable tanks.10. Interview on 6/11/26 at 11:00 a.m. with registered nurse (RN) B revealed she reviewed each resident's care plan to determine their care needs. She expected the care plan to list the resident's oxygen liters and whether oxygen was to be continuous or as needed.When a resident fell, she assessed them for injury, assisted them off the floor with a total body lift if they were uninjured, and held a staff meeting to gather information about the events that occurred before the resident fell. She would notify the resident's family, primary care provider (PCP), and the facility (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration. If the resident did not have an injury, she placed the fall report in a folder for the PCP to review during physician rounds on Tuesdays.If the resident had an injury requiring medical attention, she called the PCP and obtained an order to send the resident to the ED. She initiated neurological assessments for unwitnessed falls or any fall involving a head injury, and she woke residents up as needed to complete the assessments. The nurses could add or change fallˆrelated interventions in the care plan.11. Interview on 6/11/26 at 12:40 p.m. with administrator A revealed she became aware of the 3/2/26 incident involving resident 1 later that afternoon, after he was sent to the ED. She confirmed the investigation was initiated on 3/3/26 by herself and MDS coordinator C. She stated that what was documented on the FRI reflected what happened and what was completed.12. DON H was no longer employed at the facility and was not available for an interview during the survey.13. Review of the provider's revised 2/11/26 Falls policy revealed It is the facility's goal to provide a safe environment that is free from accident hazards over which the facility has control and provides supervision and assistive devise to each resident to prevent avoidable accidents. Procedure: If a fall occurs, the designee nurse will complete the following: d. for every suspected head injury or unwitnessed fall neuros will be completed if resident cannot state whether or not they hit their head.(see neuro policy). The care plan will be reviewed and revised as needed with appropriate interventions. Falls are discussed at morning meeting. Appropriate interventions will be placed according to the resident's individual needs. It is important that the resident's individual medical and cognitive condition be considered prior to the initiation of any intervention. Staff will encourage resident and family to be active in the plan to prevent falls and their related injuries.14. Review of the provider's reviewed 2/11/26 Neurological Checks policy revealed In the event that a resident has hit their head, or this is suspected, neurological checks will be initiated by the Charge Nurse or designated licensed professional. All neurological checks will be done at the following intervals: At the time of the incident, every 15 minutes x 4, every 30 minutes x 4, every hour x 2, then every shift for 72 hours after the incident occurred. In the event that a neurological change is seen, staff will increase checks to every 15 minutes until the primary physician can be reached for further instruction. Primary physician will be notified after the initial assessment and stabilizing of the resident with serious injury. If neurological checks are discontinued early, make a progress note as to why. When neurological check flow sheet is complete, place in medical records. Nursing staff will keep physician updated on resident condition. Primary physician will be notified with any suspected changes in the resident condition as noted with subsequent neuro checks (i.e., behavior changes, decrease consciousness, headache, lethargy, weakness, numbness, eye movement problems, double vision, difficulty with speech, confusion, disorientation, gait or balance disturbance or drainage from ears/nose.) Family will be notified and updated per each individual resident/family wishes.15. Review of the provider's effective date 1/1/2019 Oxygen Concentrator policy revealed procedure: 6. Move power switch lever to ON. 7. Turn flow rate control slowly clockwise until center of ball in flow rate indicator moves up to number of liters per minute as ordered by physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facilityˆreported incident (FRI) review, interviews, record review, and policy review, the facility did not adequately implement policies and procedures to ensure proper supervision and safe use of required oxygen equipment. This failure resulted in one of one sampled resident (resident 1) being left without prescribed oxygen for one hour and fiftyˆfive minutes, identified by him falling out of bed on 3/2/26. When Licensed Practical Nurse (LPN) D assessed the resident, his oxygen saturation level was 60%. Findings include:1. Review of the provider's 3/3/26 SD DOH FRI revealed on 3/2/26 at 3:35 p.m., resident 1 was found on his fall mattress (padded mat placed directly on the floor) next to his bed by licensed practical nurse (LPN) D. While assessing resident 1, LPN D and CNA G identified that resident 1's oxygen concentrator (a device that filters room air into purified oxygen) was turned off, although his nasal cannula (NC) tubing (flexible tubing that delivers oxygen through the nose) was on the resident and attached to the concentrator. Resident 1 had a physician's order to receive oxygen continuously at a rate of 3 liters (L) per minute. His oxygen saturation was 60% when he was found on the floor and increased to 93% when his concentrator was turned on. Resident 1 did not get up for supper on 3/2/26 due to drowsiness. CNA G informed administrator A during resident 1's fall investigation that CNA I assisted resident 1 to bed at 1:40 p.m. after lunch. The CNAs were only responsible for turning oxygen concentrators and portable tanks on and off. Resident 1 was unable to do that due to vascular dementia (a form of cognitive decline caused by reduced or blocked blood flow to the brain, often from strokes or small vessel damage). He was last observed in bed at 3:15 p.m. by LPN D before being found on the floor at 3:35 p.m. CNA G reported seeing resident 1 in bed sleeping multiple times between 2:00 p.m. and the time of the fall. CNA I stated she did not know if she turned resident 1's concentrator on. On 3/3/26 at 8:30 a.m., Administrator A and Minimum Data Set (MDS) coordinator C started an investigation into the fall and concerns of neglect based on the fall report. CNA I's employment was suspended pending the investigation, and she left the faciity on 3/3/26.At 10:10 a.m. on 3/3/26, physician's assistant (PA) J evaluated resident 1 with his power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) present, and ordered that the resident to be transferred to the emergency department (ED) for assessment of increased oxygen needs, possible aspiration (when swallowing instead of a substance going down the esophagus into the stomach, the substance goes down the windpipe and into the lungs), and postˆfall evaluation. Resident 1 was transferred to the ED at 11:50 a.m. and returned to the facility at 4:50 p.m. The ED evaluation indicated resident 1's troponin (a heart-specific protein in the blood) was elevated, and intravenous (IV) fluids were administered. Documentation was received with an undated list of staff who received education on oxygen-related neglect. Audits were completed from 4/17/26 through 5/27/26, checking if resident 1 and all other residents on continuous oxygen were wearing their oxygen appropriately and as ordered. The audits indicated that the residents reviewed were wearing their oxygen as ordered. 2. Review of resident 1's electronic medical record (EMR) indicated he admitted to the facility on [DATE]. His 3/17/26 Brief Interview for Mental Status (BIMS) was 0, which indicated his cognition was severely impaired. He had a diagnosis of obstructive sleep apnea (chronic disorder where the upper airway repeatedly collapses during sleep, blocking airflow), alzheimer's disease (irreversible brain disorder that destroys memory, and thinking skills),dementia (decline in cognitive abilities), acute and chronic respiratory failure with hypoxia (underlying, long term breathing disorder suddenly worsens, causing dangerously low oxygen levels in the blood), emphysema (progressive, irreversible lung disease where the tiny air sacs in the lungs are gradually destroyed), chronic obstructive pulmonary disease (lung disease that blocks airflow), peripheral vascular disease (narrowed or blocked blood vessels outside the heart and brain), congestive heart failure (the heart muscle becomes too weak to pump blood), and myocardial infarction (heart muscle (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is severely restricted or completely blocked).His undated care plan indicated on 8/26/23, the facility initiated that resident 1 has COPD and chronic respiratory failure. He was dependent on supplemental oxygen. He would remain free of secondary complications. There was no documented oxygen liter flow or amount of oxygen for resident 1 in his care plan. His 3/17/26 fall risk evaluation score was 15, which indicated he had a high risk for falling. His 3/2/26 progress note, completed by LPN D, indicated that the primary care physician (PCP) would evaluate resident 1 on 3/3/26 during the physician rounds. No documentation indicated that the PCP was called or faxed regarding resident 1's fall on 3/2/26. There was no documentation of the resident 1 going to the emergency department on 3/2/26.3. Review of the investigation of resident 1's fall on 3/2/26 indicated that the administrator discussed the fall with CNAs G and I, and LPN D on the evening of 3/2/26 to confirm their interactions with resident 1. None of those three staff members noticed if the oxygen concentrator was turned on for resident 1 when he was lying in bed until 3:35 p.m., when LPN D went in to give him his medications and found him lying on the floor. His POA was notified of his fall and current condition at 7:40 p.m. There was no documentation that the resident 1's PCP was notified of his falling incident on 3/2/26.4. Interview on 6/10/26 at 2:10 p.m. with MDS coordinator C revealed she was not able to recall the incident with resident 1 on 3/2/26 in detail. She directed the surveyors to refer to resident 1's incident documentation. 5. Interview on 6/10/26 at 2:33 p.m. with CNA G revealed she observed the residents as she made her rounds in the hallway, and resident 1 was lying in bed each time she passed his room. She received a call over the walkie that a nurse needed assistance in resident 1's room. When she entered resident 1's room, the resident was on the fall mat on the floor, and the nurse was taking resident 1's vitals. 6. Interview on 6/10/26 at 2:54 p.m. with LPN D revealed she was the nurse assigned to care for resident 1 on 3/2/26. She passed by resident 1's room while completing her 2:00 p.m. medication pass and noticed he was sleeping. His nasal cannula was in place with the plastic prongs inserted into each nostril and the tubing placed over the top of each ear, and his fall mat was by his bed, and his positioning pillows were in place. When she returned to his room for his scheduled medications and snacks, he was on his fall mat on the floor next to his bed. She and CNA G then realized the oxygen concentrator was not turned on. His oxygen level was low, but she could not recall the exact percentage. LPN D assessed him and initiated neurological assessments. 7. Interview on 6/11/26 at 9:28 a.m. with CNAE revealed that the care plan can be reviewed to know what rate a resident's oxygen concentrator was to be set at. She indicated that the administrator or the nurses will tell the CNAs what the resident's oxygen setting should be. She indicated that the CNAs do not adjust the concentrators or regulators on the portable tanks.8. Interview on 6/11/26 at 11:00 a.m. with registered nurse (RN) B revealed she reviewed each resident's care plan to determine their care needs. She expected the care plan to list the resident's oxygen liters and whether oxygen was to be continuous or as needed. When a resident fell, she assessed them for injury, assisted them off the floor with a total body lift if they were uninjured, and held a staff meeting to gather information about the events that occurred before the resident fell. She would notify the resident's family, primary care provider (PCP), and the facility administration. If the resident did not have an injury, she placed the fall report in a folder for the PCP to review during physician rounds on Tuesdays.If the resident had an injury requiring medical attention, she called the PCP and obtained an order to send the resident to the ED. She initiated neurological assessments for unwitnessed falls or any fall involving a head injury, and she woke residents up as needed to complete the assessments. The nurses could add or change fallˆrelated interventions in the care plan.9. Interview on 6/11/26 at 12:40 p.m. with administrator A revealed she became aware of the 3/2/26 incident involving resident 1 later that afternoon, after he was sent to the ED. She confirmed the investigation was initiated on 3/3/26 by herself and MDS coordinator C. She stated that what was documented on the FRI reflected what happened and what was completed. 10. DON H was no longer employed at the facility and was not available for an interview during the survey. 11. Review of the provider's effective date 1/1/2019 Oxygen Concentrator policy revealed procedure: 6. Move power switch lever to ON. 7. Turn flow rate control (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	slowly clockwise until center of ball in flow rate indicator moves up to number of liters per minute as ordered by physician.