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	04/25/2024

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 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 49958 Based on interview, observation, and review of the resident admission packet, the provider failed to ensure the ombudsman and South Dakota Department of Health (SD DOH) contact information had been posted in a location accessible to all 35 current residents, visitors, and families. Findings include: 1. Interview with the resident council on 4/24/24 from 1:00 p.m. through 1:35 p.m. revealed the residents were: *Unaware where to find contact information for the ombudsman (resident advocate). *Not aware they could contact the SD DOH directly or file a complaint with the SD DOH. 2. Observation on 4/24/24 at 1:40 p.m. and again on 4/25/24 at 2:16 p.m. revealed the following: *The ombudsman contact information was posted in the entryway vestibule and the social worker's office. -In the entryway vestibule, the information was posted at standing-eye-level and required a door code to access the area. -In the social worker's office, there was a poster on the wall above the bookshelf. It was posted near the ceiling. The social worker's office was not always accessible to the residents. *There was no SD DOH contact information posted anywhere in the facility. *There was no statement posted that the resident could file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations. 3. Interview on 04/25/04 at 2:08 p.m. with administrator A confirmed: *The ombudsman's contact information was posted only in the social worker's office above a bookshelf. *The SD DOH contact information was not posted. (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

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*A statement that the resident could file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations was not posted. *A description of how to file a complaint with the state survey agency, SD DOH, was not posted. 4. Review of the admission handbook revealed: *The table of contents listed State and Federal Contacts was on page 19. *There was no page 19. *The State and Federal Contacts started on page 18. *The page after page 18 was labeled page 2. *Page 2 had contact information for the state ombudsman program, but it was not the current contact information. *The SD DOH complaint coordinator's phone number was not correct.

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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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 49958 Based on interview, observation, and policy review, the provider failed to make the most recent survey results accessible to all residents and their representatives. Findings include: 1. Interview with the resident council on 4/24/24 from 1:00 p.m. through 1:35 p.m. revealed the residents were unaware of their right to read the state survey results or where to find them. Observation of the lobby and public areas on 4/24/24 at 1:40 p.m. and again on 4/25/24 at 2:16 p.m. revealed the survey results had not been made available. Interview on 04/25/04 at 2:08 p.m. with administrator A confirmed: *The survey results were not currently posted. *The survey binder had been removed from the front lobby in January 2024 after a water leak. Review of the facility resident rights document in the admission packet provided to residents revealed the right to .examine the results of the most recent survey of [provider's name] conducted by Federal or State surveyors and any plan of correction in effect. Results are located at the nurses' station and next to the business office.

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on record review, interview, and policy review, the provider failed to implement a revised advanced directive for one of sixteen sampled residents (32) reviewed for advance directives. Findings include: 1. Review of resident 32's paper and electronic medical record (EMR) revealed: *The dashboard indicated full code. (Individual desire for cardiopulmonary resuscitation [CPR] to be initiated if their heart stopped.) *The physicians' order dated [DATE] indicated full code. *The care conference notes dated [DATE] indicated Code status was changed from Full Code to DNR [do not resuscitate]. Provider was faxed. Interview on [DATE] at 11:06 a.m. with administrator (ADM) A revealed: *It was her expectation that staff would look at the EMR dashboard to find a resident's current code status. *She recalled the power of attorney (POA) changed resident 32's code status at the last care conference that was held on [DATE]. *She stated, I should have followed up with a new Expressions of Healthcare Preferences form. *It was her expectation that when a resident code status changed: -The Expression of Health Care Preferences form would have been completed with the resident or the resident's POA. -That form would have been sent to the physician for signature and uploaded to the EMR. -The physician orders and dashboard would have been updated. *She confirmed that she didn't follow up, and that the steps above had not been completed. Interview on [DATE] at 11:02 a.m. with ADM A revealed she: *Provided an Expression of Healthcare Preferences form for resident 32 dated [DATE]. *Provided a copy of a stamp that was typically stamped on the physicians' order. *Indicated that the stamp provided the steps that should be followed after receiving all physician's order. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Indicated they did not have an Advance Directives Policy as requested but provided a Denoting Code Status policy. Review of resident 32's Expression of Healthcare Preferences form revealed the form: *Indicated, I DO NOT desire cardiopulmonary resuscitation (CPR). *Was signed by the resident's POA on [DATE]. *Was signed by the physician on [DATE]. *Had not been stamped with the stamp mentioned above. Review of the providers'[DATE] Denoting Code Status policy revealed: *Upon admission, and after orders for advance directives have been received, an area by the resident's door is marked to denote their code status. *The policy did not mention: -The use of a stamp. -The steps or expectations indicated above by ADM A.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46453 Based on observation, interview, and record review, the provider failed to ensure a clean and homelike environment was maintained in the following areas: *The activities room. *Resident rooms (1, 4, 5, 9, 13, 17, and 22). *The surfaces of the mechanical lifts. *The hand sanitizer dispensers. *The scale room. Findings include: 1. Observation on 4/23/24 at 8:13 a.m. in the activities room revealed: *There were glitter and confetti pieces on the tables and on the floor. *The counters were cluttered with several art and craft supplies that had not been put away (paper, puzzles, games, painting supplies, potting soil, crayons, colored pencils, markers). *There were dust bunnies, dead leaves, and dirt particles on the floor throughout the room. 2. Observation on 4/23/24 at 8:36 a.m. in the scale room revealed: *The carpet had stained spots throughout the room. *There were bits of what appeared to be torn paper scattered on the floor. *The scale itself had flakes of an unidentified white material and was missing pieces of the plastic covering on the base. 3. Observation on 4/23/24 from 8:41 a.m. to 9:24 a.m. in the 100-hallway revealed: *The hand sanitizer drip tray outside of room [ROOM NUMBER] was dirty with dust and congealed hand sanitizer. *Resident 22's room had: -Scratches on the walls near the dresser. -A missing a chunk of wood with sharp edges on the bathroom door. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-A shelf above the bathroom sink that was visibly dirty with an unidentified substance. *Resident 17's room, had a cord between the bed and the TV taped to the floor. The tape was peeling away, creating a potential tripping hazard. *Resident 9's room had sharp edges on the edge of the entry door. *Resident 5's room had a bed rail and several other items cluttered on the floor. 4. Observation and interview on 4/23/24 at 9:19 a.m. with resident 1 in her room revealed: *Her walker had a layer of dust buildup on the tennis balls on the feet of the walker. *She stated her room was awful and she wished her room was cleaner. 5. Observation on 4/23/24 from 9:35 a.m. to 9:56 a.m. throughout the facility revealed there were at least 10 hand sanitizer drip trays that were soiled with congealed hand sanitizer and dust. 6. Observation and interview on 4/23/24 at 10:29 a.m. with resident 4 in his room revealed: *Long streak marks, chunks of paint, and exposed drywall areas missing along the bottom left edge of the wall. -At least three different areas where the drywall was exposed. -A two-foot missing section of the baseboard. -The remaining baseboard was peeling away from the walls. *He mentioned his wheelchair scrapes up against that side of the wall. *His bedside table was stained with a scattered clear glossy substance. It appeared to be sticky. 7. Observation on 4/23/24 at 10:52 a.m. of the E-Z Way stand aide labeled #5 revealed the foot base was filthy with a buildup of an unidentified orange crust, the leg brace had specks of unidentified white flakes, and the rubber safety caps were missing from where the sling was hooked onto the machine. 8. Observation on 4/23/24 at 11:05 a.m. of the E-Z Way stand aide labeled S1 revealed the foot base was filthy with dirt and food crumbs and was missing several areas of paint with rusty metal exposed. 9. Observation on 4/23/24 at 12:16 p.m. in the 200-hallway tub room revealed: *The tub chair had several areas that were cracked, broken, rusted, and missing plastic pieces. *The top of the storage shelf was unclean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Observation on 4/23/24 at 2:52 p.m. of the E-Z Way stand aide labeled 3 revealed: *There was a buildup of food particles and dirt in the foot base. *The rubber safety caps were missing from where the sling was hooked onto the machine. *One of the wheels was missing the protective covering. 11. Interview on 4/23/24 at 4:18 p.m. with resident 13's daughter revealed: *She wished her mom's room was kept in a cleaner condition. *When she visited, the floor in resident 13's room frequently had dust bunnies under and around the bed. *The bedside table was often sticky with an unknown residue. *The flooring tiles near the window were cracked. *The common areas, such as the activities room, were always messy and disorganized. -Dirt and dust were commonly seen on the floor. 12. Observation on 4/24/24 at 8:34 a.m. in the activities room revealed it was in the same condition as stated previously. 13. Observations on 4/24/24 from 8:36 a.m. to 8:50 a.m. throughout the facility revealed that the hand sanitizer drip trays remained in the same condition. 14. Observation on 4/24/24 at 10:21 a.m. in resident 13's room revealed: *Several floor tiles beneath her window were cracked. -One of the tiles had a physical bump from the cracks. -There was about a half-inch gap between the bottom of the baseboard and the floor tiles. 15. Observation on 4/24/24 from 10:43 a.m. to 10:53 a.m. throughout the facility revealed the mechanical lifts were in the same condition as stated previously. 16. Interview on 4/24/24 at 4:10 p.m. with business office manager J revealed: *He was a certified nurse aide (CNA) and helped fill in when needed. *If he saw something that needed fixing, he would write it in the maintenance request book located in the CNA room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*When he was in resident rooms, he normally looked for call light placement, not necessarily for environmental concerns that needed to have been fixed. 17. Interview on 4/25/24 at 9:28 a.m. with environmental services technician G about her normal cleaning routine revealed: *If she saw something that needed fixing, she verbally informed maintenance director D. *She had been the only housekeeper that week. *She was aware of the broken tiles in resident 13's room but had not informed maintenance director D. *She was aware of the state of resident 4's wall, but she explained that management knew about that. *She was not aware that the activity room was not clean. *A resident's room was deep cleaned when they changed rooms or if they were discharged . *There was no regular deep cleaning schedule if a resident had been living there for a long time. *The nursing staff were responsible for cleaning the resident mechanical lifts. 18. Observation on 4/25/24 at 9:42 a.m. of E-Z Way stand aide labeled 4 revealed there were food crumbs and pieces of cashew nuts in the foot base. 19. Interview on 4/25/24 at 10:19 a.m. with maintenance director D about building repairs revealed: *He checked the maintenance request book every morning. *He performed room checks once a month to see what needed to be repaired. *When asked if he kept a record of items that needed fixing or things that had been fixed already, he tapped his head and said he kept a mental note. *Larger repairs, like patching holes in walls and replacing the baseboard, was usually performed when the resident moved out or when the resident was not in the room. *He was aware of the needed repairs in resident 4's room. -He recently replaced a hole in that wall, explaining that was why part of the baseboard was missing. *He was constantly repairing scrapes in the walls from resident wheelchairs. *He was not aware of the broken tiles in resident 13's room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	20. Interview on 4/25/24 at 10:29 a.m. with CNA E about the mechanical lifts revealed: *Nursing staff were responsible for cleaning the mechanical lifts. *Bleach wipes were used to clean the high-touch areas in between each resident use. *She thought that the night staff were responsible for deep cleaning the mechanical lifts. *She agreed there were cleanliness concerns with the mechanical lifts. 21. Review of the provider's Maintenance Requisition from 12/15/23 through 4/22/24 revealed: *There was a note from 2/20/24 that read, Please have housekeeping check request log daily - does not look like things are being followed up on. *A request was submitted on 3/19/24 that read, Rm. 208 hole in wall behind bed (headboard). -The request had not been marked as completed by the time of the survey. *A request was submitted on 4/7/24 that read, room [ROOM NUMBER]: bed control cord wires exposed. -The request had not been marked as completed by the time of the survey.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49958 Based on interview, observation, admission packet review, policy review, and plan of correction review, the provider failed to: *Make information available on how to file a grievance and the location of the grievance forms readily available to residents and their representatives. *Designate who the grievance official was. Findings Include: 1. Interview with the resident council on 4/24/24 from 1:00 p.m. through 1:35 p.m. revealed: *The residents were not aware of who the grievance official was. *The residents were not aware how to file a grievance or where to find the necessary forms. Observation of the lobby and the public area in the center of the facility around the nursing station on 4/24/24 at 1:40 p.m. and again on 4/25/24 at 2:16 p.m. revealed the grievance official contact information, how to file a grievance, and the grievance forms were not in prominent locations that would be readily available to anyone with a grievance. Interview on 04/25/04 at 2:08 p.m. with administrator A revealed: *She was the grievance official and handles all the paperwork. *It was her expectation that residents write it [the grievance] on regular paper and that she would complete the grievance form. *Information on the grievance process was provided to residents at the November 2023 resident council meeting but she was unable to provide those resident council minutes. *Grievance information was kept in a black plastic pocket file hung on the wall above the nurses' station and noted the label on the file was missing. *The forms were kept where residents could not reach them or prevent one of the residents from taking all of them. -She explained one of the residents had a habit of taking items from the nurses' station. Review of the provider's 10/24/23 admission packet revealed: * .there are also forms by the front office you can fill out with your concerns or thoughts. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The packet did not specify who the grievance official was. *There was no grievance form located in the packet. Review of the provider's Grievance policy effective 10/24/23 revealed: *Upon request, the facility will provide residents or their representative(s) information regarding the internal grievance process including whom to contact to file a grievance. *The policy did not specify who the grievance official was. Review of the provider's plan of correction for the survey completed on 10/4/23 revealed: *Resident Council will be held on 11/1/23 to discuss the new Grievance Policy and Procedure and where to locate them and announcing the Social Services Designee as the grievance official. *Grievance forms will be located outside the nurse's station and included in the Resident Admission Handbook as well as .next to the Administration office with clear signage and in plain view. *The provider was found in compliance with the plan of correction at the time of the revisit that was conducted on 11/7/23.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, record review, and policy review, the provider failed to develop, revise, and implement a comprehensive person-centered care plan that addressed nail care and range of motion for two of fourteen sampled residents (3 and 5). Finding Include: 1. Observation and interview on 4/23/24 at 9:19 a.m. with resident 3 revealed: *There was a picture on the wall with instructions on how to put on a right-hand splint and a schedule for the times that the splint was to have been put on. *Resident 3 indicated she had not worn that splint for a long time. *She rested her right hand in her lap. *When asked to lift her arms she was unable to lift her right arm. *She stated, No, none, when asked about range of motion exercises and if anyone helped her to move her arms. *She indicated that she: -Had been in therapy but was not currently. -Wanted an exercise program for her right arm. Interview on 4/24/24 at 2:35 p.m. with registered nurse (RN) N revealed that resident 3 only wore the hand splint at night, and I don't know any more about it. -That contradicted resident 3's report that she had not been wearing the splint. Review of resident 3's paper and electronic medical record (EMR) revealed: *An admitted [DATE]. *Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and contracture of muscle; right hand. *The most recent annual comprehensive Minimum Data Set (MDS) with an assessment reference date of 5/2/23 that indicated: -Functional Limitation in Range of Motion: Upper extremity. -Impairment on one side. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She has worked with therapy in the facility but is currently doing restorative. *There was no current documentation in the EMR of a restorative program or use of the right-hand splint. *The Occupational Therapy Discharge Summary dated 9/26/23 indicated Splint and Brace Program Established/Trained: Splint on at night off in the morning. Review of resident 3's care plan with a revision date of 5/19/23 revealed: *A goal of, To voice adequate pain control and be able to participate in therapy. *An intervention of, I have a contracture of my left hand r/t [related to] my CVA [cerebral vascular accident (stroke)]. I am working with OT [occupational therapy]. *The care plan had not been revised after discharge from occupational therapy on 9/26/23. *There were no goals or interventions related to her right-hand contracture. *There were no goals or interventions related to limited range of motion (ROM) of her right arm. Interviews on 04/25/24 at 11:32 a.m. and again on 4/25/24 at 12:26 p.m. with administrator A revealed: *She was unable to locate documentation on the use of a hand splint for resident 3. *I don't have anything on [resident 3's] splint, that would be OTR (registered occupational therapist) O. *In reference to the sign hanging in resident 3's room, she stated, I don't think the sign should be in her room, I will find out. She was unable to provide confirmation. *They do not have a policy for the restorative nursing program. 2. Observation and interview on 4/23/24 at 11:34 a.m. with resident 5 revealed: *She had long jagged, thickened fingernails with dark colored residue under the tips. -The nails were brownish yellow in color and the growth was both upward and beyond the fingertip. *She had a blue foam roll in her left hand. *Both her left and right hands were resting in her lap with her fingers curled under. *When asked to open her finger, she demonstrated minimal movement. *She stated: (continued on next page)

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	435080	A. Building B. Wing	04/25/2024

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She was not happy about not receiving exercises for her hands. -No one moves my hand. Observation and interview on 4/23/24 at 9:45 a.m. and again on 4/25/24 at 10:03 a.m. with resident 5 revealed: *She had a blue foam roll in her left hand. *The foam roll had an unidentifiable substance on it. *Her fingernails remained long and there was an unidentified orange and brown substance under her nails. *She stated she liked to look nice. *Stated she wanted to get her nails done on Thursday. Review of resident 5's EMR revealed: *An admitted [DATE]. *Diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side and weakness. *A physician order dated 7/8/23 for Blue palm protector to right hand ON in AM off at HS one time a day for skin integrity of hand due to contracture and remove per schedule. *The most recent MDS significant change in status with an assessment reference date of 7/14/23 revealed: -Functional Limitation in Range of Motion: Upper extremity .Impairment on both sides. -Functional Limitation in Range of Motion: Lower extremity .Impairment on both sides. *There was no nail care or refusal of nail care documentation in the nurse's notes, care tasks, or Treatment Administration Record. Review of resident 5's care plan with a revision date of 10/19/23 indicated: *I have history of a CVA. *I have residual hemiplegia/hemiparesis to my left side. *I have very limited ROM r/t my spinal stenosis and arthritis. *I will maintain current level of function. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-There were no interventions related to limited range of motion of her arms and legs. *I like lipstick and to look nice . *She requires one person assistance with personal hygiene. *Skin assessments were to be completed weekly. *There were no goals or interventions related to her nail care. Interview on 4/25/24 at 9:38 a.m. with certified nurse assistant (CNA) X revealed: *Nail care was provided with scheduled baths once a week by the nursing assistants. -There was no specific nail care documentation to complete. It's basic care. *Skin assessments were completed by the nurse on bath day. *The activities department provided a nail class on Thursdays each week. *She provided a bath to resident 5, but: -CNAs did not complete resident 5's nail care. -A nurse does her nails, both toes and fingers. *Resident 5 is not always receptive to baths or nail care. Interview on 4/25/24 at 9:31 a.m. with licensed practical nurse F revealed: *Resident 5 goes to nail class on Thursdays with activities but sometimes refuses. *It was her expectation that: -CNAs can care for [resident 5's finger] nails. -That was typically completed on bath days. Interview on 4/25/24 at 9:51 a.m. with activities director R revealed: *Resident 5 attended nail class occasionally depending on her mood. *We just polish or [NAME] her nails. *We are careful about her nails. 3. Interview on 4/25/24 at 12:26 p.m. director of nursing (DON B) revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Residents 3 and 5 had not been assessed and was not receiving any restorative program. *Care plans were updated when MDSs were completed or when changes were identified. Review of the provider's Care Planning Process policy reviewed 10/27/21 and 4/25/24 revealed: *To insure a comprehensive, individualized plan of care for each resident. * .each resident will have an individualized plan of care which addressed the resident's needs and severity of condition, impairment disability or disease . *It is the responsibility of the IDT [interdisciplinary team] members to assess the resident, individualize the plan of care, evaluate the effectiveness and [of] the plan of care as a resident's needs change . Review of the RAI [resident assessment instrument] Version 3.0 Manual dated October 2023 revealed: *Good assessment is the starting point for good clinical problem solving and decision making and ultimately for the creation of a sound care plan. *The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, record review, and policy review, the provider failed to ensure an ongoing restorative nursing program for two of two sampled residents (3 and 5) at risk for a decline in range of motion. Findings include: 1. Observation and interview on 4/23/24 at 9:19 a.m. with resident 3 revealed: *There was a picture on the wall with instructions on how to put on a right-hand splint and a wearing schedule for that splint. -Resident 3 indicated she had not worn that splint for a long time. *She rested her right hand in her lap. *When asked to lift her arms she was unable to lift her right arm. *She stated, No, none, when asked about range of motion exercises and if anyone helped her to move her arms. *She indicated that she: -Had been in therapy but was not currently. -Wanted an exercise program for her right arm. Review of resident 3's paper and electronic medical record (EMR) revealed: *An admitted [DATE]. *Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side and contracture of muscle; right hand. *The most recent annual comprehensive Minimum Data Set (MDS) with an assessment reference date of 5/2/23 indicated: -Functional Limitation in Range of Motion: Upper extremity. -Impairment on one side. -She has worked with therapy in the facility but is currently doing restorative. --There was no documentation to support her participation in a restorative program. *The care plan with a revision date of 5/19/23 indicated: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-A goal of, To voice adequate pain control and be able to participate in therapy. -An intervention of, I have a contracture of my left hand r/t [related to] my CVA [cerebral vascular accident (stroke)]. I am working with OT [occupational therapy]. -No intervention related to her right hand contracture. *The 9/26/23 Occupational Therapy Discharge Summary dated indicated Splint and Brace Program Established/Trained: Splint on at night off in the morning. *There was no documentation in the EMR of a restorative program or use of the right-hand splint. 2. Observation and interview on 4/23/24 at 11:34 a.m. with resident 5 revealed: *She had a blue foam roll in her left hand. *Both her left and right hands were resting in her lap with her fingers curled under. -When asked to open her fingers, she demonstrated minimal movement. *She stated: -She was not happy about not receiving exercises for her hands. -No one moves my hand. Review of resident 5's EMR revealed: *An admitted [DATE]. *Diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side and weakness. *A physician order dated 7/8/23 for palm protector to right hand . for skin integrity of hand due to contracture . *The most recent MDS significant change in status with an assessment reference date of 7/14/23 revealed: -Functional Limitation in Range of Motion: Upper extremity .Impairment on both sides. -Functional Limitation in Range of Motion: Lower extremity .Impairment on both sides. *The care plan with a revision date of 10/19/23 indicated: -I have history of a CVA. -I have residual hemiplegia/hemiparesis to my left side. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-I have very limited ROM [range of motion] r/t [related to] my spinal stenosis and arthritis. -I will maintain current level of function. Interview on 4/25/24 at 8:48 a.m. with physical therapy assistant (PTA) P revealed: *She was familiar with both resident 3 and resident 5. *Neither of those resident were receiving skilled therapy. *In regards to a restorative nursing program she stated, I believe they should both [resident 3 and resident 5] have a program. -Those programs would have been provided to [director of nursing (DON B)]. Interview on 4/25/24 at 10:50 a.m. with registered occupational therapist (OTR) O revealed: *Resident 3 was not currently receiving any skilled therapy services. *Resident 3 wore a hand splint and: -She stated, I am not sure if she [resident 3] is tolerating it. --She was uncertain if resident 3 had a restorative program. *It was her expectation that if therapy recommended a splint schedule or restorative program when the resident was discharged from therapy, nursing would complete it or communicate if there was a problem. *Resident 5 was not currently receiving any skilled therapy services. *She was uncertain if resident 5 had a restorative program. *Restorative exercise and splinting programs, when written by a therapist, were given to (DON) B. Interview on 04/25/24 at 11:32 a.m. and again on 4/25/24 at 12:26 p.m. with administrator A revealed: *She was unable to locate documentation on the use of a hand splint for resident 3. *In reference to the sign hanging in resident 3's room, she stated, I don't think the sign should be in her room, I will find out. She was unable to provide confirmation. *They do not have a policy for the restorative nursing program. Interview on 4/25/24 at 12:26 p.m. DON B revealed: *Restorative is a nursing program she leads. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Therapy involvement is limited to recommendation. Restorative programs will be modified by nursing. *I don't need to communicate with therapy if I change the program that they wrote. *She had created a restorative User-Defined Assessment (UDA) in point click care (PCC) [the EMR software]. *Not every resident has been assessed yet using that UDA and: -As residents would come due for their annual MDS, she would evaluate the need for restorative programs and put them back in place. -Residents 3 and 5 had not been assessed and did not have restorative programs.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interviews, record review, and policy review, the provider failed to ensure there were sufficient nursing staff to ensure call lights were answered in a reasonable time for five of thirty-five sampled residents (3, 4, 5, 13, and 21). Findings include: 1. Interview on 4/23/24 at 10:29 a.m. with resident 4 in his room revealed he: *Pointed out his pendant call light and stated its function. *Mentioned that sometimes he had to wait 20 to 30 minutes for someone to answer the call light. *Did not use the call light frequently. Review of resident 4's call light audit report from 2/24/24 to 4/24/24 revealed: *The report was generated from 2/24/24 to 4/24/24, but there was no data on the report before 4/5/24. *There were three call light wait times over 15 minutes. *The longest call light wait time was 40 minutes. 2. Interview on 4/23/24 at 11:01 a.m. with resident 3 about call light wait times revealed that she noticed she had to wait longer at nighttime. Review of resident 3's call light audit report from 2/24/24 to 4/24/24 revealed: *There were 19 call light wait times over 15 minutes. *The longest call light wait time was 30 minutes. 3. Interview on 4/23/24 at 11:41 a.m. with resident 5 revealed that she sometimes waited for hours for someone to come help her at night when she used her call light. Observation on 4/23/24 at 11:48 a.m. revealed that resident 5's call light was not functioning. -When the button was pressed it did not show up on call light report. -It was discovered that the battery needed to have been replaced. Review of resident 5's call light audit report from 2/24/24 to 4/24/24 revealed there was one time on the evening of 4/22/24 where her call light wait time was 40 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	46453 4. Interview on 4/23/24 at 2:30 p.m. with resident 21 in her room revealed she: *Was there for therapy after she fell at home and broke her hip. *Had to wait long periods of time for staff to help her, but she did not keep track of how long she waited. *Was not supposed to stand up on her own but did that anyway because when you have to go, you have to go. *Was incontinent at times because she could not make it to the bathroom in time. *Was able to sense when she needed to use the restroom. *Wore incontinent briefs for the occasional accident. Review of resident 21's call light audit report from 4/8/24 to 4/24/24 revealed: *There were 25 call light wait times over 15 minutes. *The longest call light wait time was 109 minutes. *Specific long call light wait times that correlated to her incontinence episodes were as follows: -4/11/24, call light triggered at 12:30 p.m., alarm cleared at 1:00 p.m. after 30 minutes. -4/19/24, call light triggered at 4:02 a.m., alarm cleared at 4:25 a.m. after 23 minutes. -4/20/24, call light triggered at 7:05 a.m., alarm cleared at 7:28 a.m. after 23 minutes. Review of resident 21's bladder incontinence records revealed she was incontinent on the following dates and times: *4/11/24, 4:37 a.m. *4/13/24, 7:49 p.m. *4/14/24, 9:05 p.m. *4/17/24, 5:06 a.m. *4/19/24, 4:59 a.m. *4/21/24, 8:21 p.m. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of resident 21's bowel incontinence records revealed she was incontinent on the following dates and times: *4/10/24, 5:19 a.m. *4/11/24, 1:58 p.m. *4/20/24, 8:56 a.m. *4/21/24, 8:21 p.m. Review of resident 21's 4/11/24 admission Minimum Data Set assessment revealed she was occasionally incontinent of urine and frequently incontinent of bowel. Interview on 4/24/24 at 3:35 p.m. with licensed practical nurse (LPN) F about bowel and bladder incontinence charting revealed: *Some staff chart on a resident's continence right away after assisting that resident, while others chart later. *They would write quick notes on the pocket care plan to chart on later. Interview on 4/24/24 at 3:44 p.m. with certified nurse aide (CNA) W about charting revealed that she usually wrote whether the resident was continent or incontinent on the pocket care plan, and then charted later. Interview on 4/24/24 at 4:10 p.m. with business office manager/CNA J revealed: *He usually assisted on the floor during busier times. *If he assisted residents to use the bathroom and noted that they were continent or incontinent, he charted later. Interview on 4/25/24 at 2:23 p.m. with resident 21 revealed she: *Confirmed she was able to sense when she needed to use the bathroom. *Wore an incontinence brief for the occasional accident. *Confirmed she had a few accidents where she could not make it to the bathroom in time because she had to wait too long for staff to assist her to the bathroom. *Indicated some staff were quicker to respond than others. Interview on 4/25/24 at 3:14 p.m. with administrator A about resident 21 revealed: *When she admitted on [DATE], she was more incontinent of bowel than she was now due to adverse side effects of some medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Her physician stopped that medication and her incontinence improved. *She was aware of some of the longer call light wait times on resident 21's call light audit report. -She said, I hope it's just because they [the staff] forgot to turn the call light off. 5. Interview on 4/23/24 at 4:18 p.m. with resident 13's daughter revealed she: *Visited her mom frequently. *Noticed longer call light wait times, usually around 30 minutes. Review of resident 13's call light audit report from 2/24/24 to 4/24/24 revealed: *There were 19 call light wait times over 15 minutes. *The longest call light wait time was 46 minutes. *The resident's call light stopped functioning on 3/29/24 around 7:00 p.m. *The resident was given a different call light on 3/31/24. Interview on 4/24/24 at 10:29 a.m. with CNA E about resident call lights revealed: *There were a few different styles of call lights used. -A portable button. -A corded button attached to the wall. -A paddle button attached to the wall. *All types of call lights were connected to the staff radios. *When a resident pressed their call light, the staff's radio would audibly announce which room number needed assistance. 6. Interview on 4/24/24 at 1:00 p.m. with the resident council revealed: *It was harder to get staff to answer the call lights in the evening. *One resident stated he often waited in bathroom for 30 minutes for staff to answer his call light. -He stated that he recently waited on the toilet for 45 minutes. *Another resident stated she called the facility on her cell phone when she had to wait more than 20 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The residents stated, We have to be patient in the evening or morning. 7. Interview on 4/25/24 at 3:15 p.m. with administrator A about the long call light wait times revealed: *She was aware of the long call light wait times. *She performed a call light audit at the beginning of the month and noticed longer call light wait times in the morning around shift change. *She confirmed the night shift staff consisted of one CNA and one nurse from 10:00 p.m. to 6:00 a.m. *They changed the morning shift process to get the CNAs onto the floor sooner to assist the residents with getting up for the day. *The night shift ended at 6:15 a.m., and the morning shift started at 5:45 a.m. which allowed for a 30-minute overlap between shifts to provide time for the shift-to-shift reports. 8. Review of nursing staff schedules for March and April 2024 confirmed the day-to-day staffing pattern consisted of the following for a maximum of 35 residents: *From 10:00 p.m. until about 5:45 a.m. the next morning, there was only one nurse and one CNA scheduled. *One daytime charge nurse from 5:45 a.m. to 6:15 p.m. *One daytime treatment nurse from 5:45 a.m. to 6:15 p.m. *Three daytime CNAs from 5:45 a.m. to 2:00 p.m. *One daytime CNA from 5:45 a.m. to either 4:00 p.m. or 6:15 p.m. *Anywhere from two to four evening CNAs from 2:00 p.m. to 10:00 p.m. *One evening medication aide from 5:45 p.m. to 10:00 p.m. *One night CNA from 5:45 p.m. to 6:15 a.m. *One night nurse from 5:45 p.m. to 6:15 a.m. Review of the provider's revised 4/24/24 Call Light policy revealed: *Purpose: -To assure that resident always has a method of calling for assistance. -To promptly answer the resident's call. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Procedure: -1. When resident's call light is observed, go to resident's room promptly. -2. Turn call light off and inquire about resident's request in a friendly manner and respond as soon as possible. -3. When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it. *The policy did not define an acceptable time frame to answer call lights.

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Bethesda of Beresford	606 W Cedar Beresford, SD 57004

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49238 Based on observation, interview, record review, and policy review, the provider failed to ensure expired medications were not administered to residents, and removed and discarded for nine of thirty bulk medications in two of two medication carts. Findings include: 1. Observation on 4/25/24 at 10:20 a.m. of the 200/300 hallway medication carts with licensed practical nurse (LPN) F revealed there were several bulk medications that were past the manufacturer's expiration dates: *A bottle of Senna with an open date of 8/6, and an expiry date of 1/2024. *A bottle of TUMS, there was no open date or expiry date noted. *A bottle of multivitamins with an open date of 2/10/23 and a Best if Used By date of 3/2024. *A bottle of calcium tablets with an open date of 12/29/22, and an expiry date of 12/22/23. *A bottle of aspirin with an open date of 8/26/23 and an expiry date of 2/2024. 2. Observation on 4/25/24 at 10:55 a.m. of the 100/400 hallway medication cart with registered nurse K revealed: *An open bottle of TUMS, there was no open date, the expiry date was 6/2025. *An opened bottle of Milk of Magnesia, there was no open date, the expiry date was 4/2025. *A bottle of Tylenol with an open date of 4/10/24 and an expiry date of 3/2024. *A bottle of Senna with an open date of 3/2024 and an expiry date of 1/2024. 3. Interview on 4/25/24 at 10:40 a.m. with LPN F revealed: *She confirmed the written dates with a black Sharpie were the dates the bottles were opened to administer the medications to the residents. -Clearly, some expired medications were missed and left on the cart. -The pharmacist would come into the facility and audit the medications in the store room and the medication carts monthly. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Nurses should be checking for expiration dates before administering medications and if the medications were expired they should have removed them from the cart and prepared them for disposal. 4. Interview on 4/25/24 at 10:55 a.m. with registered nurse (RN) K revealed: *She confirmed the written dates with black Sharpie were the dates the bottles were opened and administered to the residents. -Some of those medications were outdated and should have been removed from the medication cart. -We use Milk of Magnesia up so fast it would not last until its expiration date. -Nurses should verify the expiration date before administering medications to the residents. 5. Interview on 4/25/24 at 11:30 a.m. with Administrator A revealed: *The director of nursing was out with a sick child. -Outdated medications should be disposed of and not used. *She thought the pharmacist had recently been on site to do the audit, but, I will just own it and move on. 6. Review of the provider's 4/25/24 policy and procedure for Storage of Medications policy revealed: *Medications labeled for individual residents were stored separately from the floor-stock medications. *Outdated medications were disposed of according to procedures for medication disposal. *Medication storage conditions were monitored on a monthly basis by the consultant pharmacist or pharmacy designee. *If drugs dispensed in the manufacturer's container or vial was initially broken, the container or vial would have been dated. -The nurse would place a date opened on the medication. -The expiration date of the vial or container would have been 30 days unless the manufacturer recommends another date or regulations/guidelines required different dating. -The nurse would check the expiration date of each medication before administering it. *No expired medications should have been administered to a resident. *All expired medications should have been removed from the active supply and destroyed in the facility, regardless of the amount remaining.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50015 Based on observation, interview, record review, and policy review, the provider failed to ensure necessary food safety guidelines were implemented and followed for appropriate storage and labeling of food and chemical items, appropriate monitoring of the low-temperature dishwasher, and cleaning and sanitary maintenance of one of one kitchen. Findings include: 1. Observation on [DATE] at 8:26 a.m. during the initial kitchen tour revealed: *There were approximately 35 cans of fruits and vegetables in the dry storage room with no manufacturer's date and no date when those food items were received. *There were four dented cans in the dry storage room. *The chemical sanitizer monitoring sheet for the low-temperature dishwasher was missing concentration measurements for the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] [DATE], [DATE], [DATE], and [DATE]. *The chlorine testing strips for testing the dishwasher chemical sanitizer concentration had an expiration date of [DATE]. *A bottle of liquid bleach disinfecting cleaner and two spray bottles of degreaser were sitting next to the stand mixer in the kitchen preparation area. *The ceiling vent in the dry storage room was covered with dust and grime. *The stand mixer had crusty food particles and flour on the backsplash of the mixer. -The mixer was not covered with a protective stand cover. *There was a bucket with standing water and unidentified food particles scattered beneath the plumbing pipes of one of the prep sinks. -The pipe was held up by a bungee cord. *The bottom of the convection oven had burnt food on the bottom of the oven surface. *Dust was caked behind the oven and on the top of the stove. *The ice dispenser in the dining room had a thick layer of hard water sediment around the dispenser spout, the catch grate beneath, and on the counter around the ice machine. *There was food build-up on the inside of the dishwasher doors. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Ceiling vents throughout the kitchen were dusty and covered with unidentified dark matter. *Chains above the food preparation counter that held utensils were dusty and covered with cobwebs. The serving ladles were placed directly beneath those chains and were covered with a layer of dust and grime. *The floor drain that was by the refrigerator had a green discoloration. *One measuring cup was stored inside the flour bag in a storage container. *The refrigerator floor under the shelves had a build-up of an unidentified brown substance. -A bottle of grape juice with a best used by [DATE], in the refrigerator. -Strawberry sauce dated ,d+[DATE] was in the refrigerator. -Sauerkraut dated ,d+[DATE] was in the refrigerator. -Three glasses of undated tomato juice. -Sliced cheese wrapped in plastic wrap that was undated. 2. Observation and interview with [DATE] at 3:40 pm with dietary cook I revealed: *The sink leaks when the lid to the garbage disposal was used. -The bin stopped water from leaking on the floor. *The maintenance director (MD) D was responsible for cleaning the ice dispenser. -She would run hot water down the drain every day that she worked to clean the ice tray. 3. Interview on [DATE] at 9:57 a.m. with administrator (ADM) A revealed: *There were no cleaning policies or consistent schedules for cleaning the kitchen. *There was no ice dispenser cleaning log. *MD D overseen the cleaning of the ice dispenser. 4. Observation on [DATE] at 11:30 a.m. of dietary manager (DM) C revealed that he was prepping and handling food without wearing a beard net to cover his facial hair. 5. Interview on [DATE] at 1:57 p.m. with DM C revealed: *He usually returned dented cans to the food supplier. *He was not aware that the cans of food did not have a manufacturer's expiration date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-He had never thought to date cans when they were received. *There were no cleaning schedules for the kitchen. *He was unaware that the chlorine testing strips were expired. *Scoops were not to have been left in food storage containers. *There was a policy for the use of hairnets and hairnets were to have been worn when working in the kitchen. -There were hairnets and beard nets available. -He thought that his beard was trimmed enough that he would not need to wear a beard net. 6. Interview on [DATE] at 2:45 p.m. with MD D and ADM A revealed: *The policy was to clean the ice dispensers twice a year. *They confirmed the ice dispensers, had not been cleaned in the last six months. -There were no cleaning logs for the ice dispensers. -They were aware of the hard water build-up under the ice dispenser in the dining room. 7. Review of the provider's [DATE] Sanitation of Dietary Department policy revealed the dietary staff should maintain the sanitation of the dietary department through compliance with a written and comprehensive cleaning schedule. Review of the provider's [DATE] Leftovers policy revealed: *All leftovers should have been properly covered and labeled with the name of the product and the date it was prepared. *Refrigerated leftovers should be used within 72 hours. *Items that cannot be used in 72 hours should have been placed in the freezer. Review of the provider's [DATE] Food Preparation/Food Storage Policy revealed: *The principles of first in, first out (FIFO) will be used on all areas of food storage for rotation of food items. Refer to state regulations regarding dating of stock. (Dating can assist in demonstration of FIFO[first in, first out]) *Foods which have been opened or prepared will be placed in an enclosed container, dated, and labeled. (See policy and procedure on leftovers). Cover, date, and label trays of individually poured items such as glasses of juice, milk, supplements. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Expiration dates will be checked on a regular basis and food and fluids which have expired will be discarded. Potentially hazardous foods will be discarded after three days in refrigerator. *Chemicals will not be stored near food items. Review of the [DATE] provider's user manual for low temperature dishwasher policy revealed: *Dishwasher for ADS (American Dish Service) AF-C Policy revealed sanitizer should be 6% solution of sodium hypochlorite [a chemical sanitizer]. *The initial setting is 5cc [cubic centimeter] and this should be checked regularly with a chlorine test kit. Free chlorine in the final rinse should be 50 ppm or more. However, high concentrations can cause deterioration of metal. Review of provider's undated maintenance and cleaning ice machine policy for the ice dispenser revealed maintenance and cleaning should be scheduled at a minimum of twice per year.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 46453 Based on Certification and Survey Provider Enhanced Reports (CASPER) data review, staff schedule and timecard review, and interview, the provider failed to ensure Payroll Based Journal (PBJ) (information of the provider's daily staffing hours for the care of the residents) data was accurately completed before submission to the Center for Medicare and Medicaid Services (CMS) for three of four federal fiscal quarters (Quarter 2, 2023; and Quarter 3, 2023; and Quarter 1, 2024). Findings include: 1. Review of the PBJ data submitted to CMS for the three quarters listed above revealed: *The following items were triggered: -Excessively low weekend staffing (Quarter 3, 2023 only). -Failed to have licensed nursing coverage 24 hours per day. *The infraction dates for failing to have licensed nursing coverage 24 hours per day was as follows: -Quarter 1, 2024 (October 1, 2023, to December 31, 2023): 10/7/23, 10/16/23, 11/18/23, 11/23/23, 11/27/23, 12/9/23, 12/16/23, 12/19/23, 12/23/23, 12/25/23, and 12/26/23. -Quarter 3, 2023 (April 1, 2023, to June 30, 2023): 4/1/23, 4/5/23, 4/6/23, 4/7/23, 4/8/23, 4/9/23, 4/14/23, 4/19/23, /22/23, 5/6/23, 5/29/23, 6/24/23, and 6/30/23. -Quarter 2, 2023 (January 1, 2023, to March 31, 2023): 1/1/23, 1/11/23, 1/13/23, 1/18/23, 1/28/23, 1/30/23, 2/4/23, 2/13/23, 2/18/23, 2/22/23, 2/23/23, 2/28/23, 3/1/23, 3/8/23, 3/10/23, 3/11/23, 3/13/23, 3/19/23, 3/23/23, 3/24/23, 3/25/23, 3/26/23, 3/27/23, 3/28/23, 3/29/23, and 3/31/23. 2. Review of the provider's 2023 employee staffing schedules and timecards revealed they had licensed nursing coverage 24 hours per day on the dates listed above. 3. Interview on 4/25/24 at 4:08 p.m. with administrator A regarding the PBJ staffing data revealed: *She confirmed the staffing schedules were correct and they had met the requirement to have licensed nursing coverage for 24 hours per day. *She was not aware that the staffing data had been inaccurately submitted to CMS. *The former business office manager was responsible for submitting the staffing data. -That employee stopped working for the facility in October 2023. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*She speculated that the former employee had been submitting the staffing data incorrectly. *She was unsure why the most recent quarter's staffing data was incorrect.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49238 Based on interview and policy review, the provider failed to ensure that Legionella monitoring and prevention were addressed in the infection control program, which had the potential to affect all 35 residents within the facility. Findings include: 1. Review of the provider's 10/27/21 infection prevention and control program revealed there was nothing related to the prevention and monitoring of Legionella. 2. Interview on 4/25/24 at 8:15 a.m. with administrator A about the provider's Legionella program revealed: *She was not aware of any water testing for Legionella. *Director of nursing B was the infection preventionist, but she was not present in the facility for an interview. *Maintenance director D might know more about the Legionella monitoring. Interview on 4/25/24 at 11:31 a.m. with maintenance director D about Legionella revealed: *He did not perform any testing on the facility's water supply. *They were connected to the city's municipal water system. *He contacted the city's municipal water department and learned they did not monitor for Legionella. -They only monitored the pH of the water supply, not the concentration of chlorine sanitizer necessary to prevent the growth of Legionella bacteria. *He confirmed the water had not been tested in the three years he had been working at the facility. Interview on 4/25/24 at 3:29 p.m. with administrator A revealed she confirmed they had no Legionella monitoring or prevention plan as part of the facility's infection control program.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 49238 Based on observation, interview, record review, and policy review, the provider failed to ensure the regular safety inspection of bed rails for two of two sampled residents (2 and 7). Findings include: 1. Observation and interview on 4/23/24 at 8:49 a.m. with resident 7 revealed: *She had bed rails on the bed in the up position. -She stated she had a stroke 5 years ago and could not use her right leg or arm. -She said she used the bed rails sometimes for repositioning, otherwise, they are just there. Interview with CNA X revealed: *Resident 7 used thebed rail at night, but she never observed her using them. 2. Observation and interview on 4/23/24 at 9:24 a.m. with resident 2 revealed: *She was sitting in her wheelchair in her room while CNA Y made her bed. *Resident 2 would not respond when questioned about the use of the rail. -There was one bed-rail on her bed that was near the wall. -CNA Y stated the resident did not use the bed rail. 3. Interview on 4/25/24 at 10:15 a.m. with maintenance director D revealed he: *Did not assess the bedrails. -Did not have measurements or any log with bedrail information. -Would put the bedrails on the bed when he received a physician's order. -Did not do annual checks or monitoring of those bed rails once they are placed on the residents bed. 4. Review of the providers undated Bed Inspection and Bed Rail Policy revealed: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*It was the policy of the facility to identify and reduce safety risks and hazards commonly associated with bed rail use. A duo-faceted approach would be used to achieve sustainable quality outcomes, including 1) regular bed maintenance and 2) individual bed rail evaluations. In response to the requirement of providing for a safe, clean, comfortable, and homelike environment, the facility's regular maintenance program would include regular inspection of all bed systems (e.g. rails, frames, and mattresses, and operational components) to ensure they were clean, comfortable, and safe. The facility would also ensure individual resident bed rail evaluations were performed on a regular basis. Individual bed rail evaluations would include data collection analysis and determination of potential alternatives to bed rail use. When bed rail(s) were deemed necessary and appropriate, the facility would provide education to resident or resident's representative pertaining to the risks and benefits of bed rail use. The facility's priority was to ensure safe and appropriate bed rail use. -The objective of the bed rail use policy is to determine if resident use was safe and appropriate. The interdisciplinary team would use data collected from regular bed inspections and individual bed rail evaluations to bolster care planning and positive resident outcomes. The bed rail use policy would be reviewed annually or more frequently as needed and would be integrated into the facility quality assurance and performance program.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, resident and family interview, call light audit review, and policy review, the provider failed to ensure the resident call light system was functioning for 2 of 13 sampled residents (5 and 13) out of 35 total residents. Findings include: 1. Observation and interview on 4/23/24 between 11:34 a.m. and 11:41 a.m. with resident 5 in her room revealed: *At times she waited hours at night for someone to assist her when she used her call light. *The blue call button was pushed at 11:41 a.m. -The red indicator light was not activated. -There was no indication outside the room that the resident's call light was on. Observation and interview on 4/23/24 at 11:48 a.m. with certified nurse assistant (CNA) Y revealed: *She walked past resident 5 ' s room for a second time. *When asked if resident 5 ' s call light was activated, she stated that the call light was not currently activated on her walkie [walkie-talkie]. -She carried the walkie [walkie-talkie] in her pocket, and it audibly announced which room number was calling. --It repeated that information until it was cleared by pressing the orange button on the call light. *Upon entering resident 5's room she attempted to activate the call light and stated, It's not on my walkie [walkie talkie] .the red light should be on. The batteries could not be working. *She stated she would not know if the call light was not working unless someone told her. *She explained that there was a maintenance book to let maintenance know when things were broken. *She assisted resident 5 out of her room. *She took the call light box to maintenance now and get it fixed right away. Observation and interview on 4/24/24 at 10:18 a.m. with licensed practical nurse F revealed: (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She arrived at resident 5 ' s room because the call light had been activated. -Had heard the call light activation on her walkie [walkie-talkie]. *She confirmed that the red light was not lit. -Stated that it should be lit [indicating the call light was activated] because it was on her walkie. *When asked how she would know the call light was broken, she said Someone would have to say they called, and no one answered. *She changed the batteries herself at times when the call lights were not working. Review of resident 5's call light audit report revealed the following: *There was no indication that the batteries were low. *There was no record of the call light having been activated when the call light button was pressed on 4/23/24 at 11:41 a.m. *The call light started working again at 11:59 a.m. 46453 2. Interview on 4/23/24 at 4:18 p.m. with resident 13's daughter revealed: *She was visiting resident 13 recently and the call light was not working. -They pressed the button, but nothing happened. -After waiting for some time, she went to find a staff member for help. *The staff member discovered at that time that resident 13's call light had stopped working. *They had given resident 13 a different call light that was functioning properly. Interview on 4/24/24 at 10:21 a.m. with resident 13 revealed: *She remembered when her call light stopped working a couple of weeks ago. *Staff had given her a different call light to use. Interview on 4/24/24 at 10:29 a.m. with CNA E regarding resident call lights revealed: *When a resident pressed the call light, the staff's radio would announce which room number needed help. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There was an alarm in the CNA room that alerted when a portable call light's battery was low. *They were not able to reassign the call light room number if they had to give a resident a new call light. -For example, resident 13 had the call light assigned to room [ROOM NUMBER], even though resident 13 was not in room [ROOM NUMBER]. -The radio would announce that room [ROOM NUMBER] needed help if resident 13 pressed her call light. -Staff would write down what resident had which call light on a piece of paper or sticky notes attached to the call light computer in the CNA room. *She agreed that the system could have been confusing since several residents were using call lights that were not assigned to their room numbers. Interview on 4/24/24 at 1:12 p.m. with administrator A regarding resident call lights revealed: *She received a text on 3/31/24 stating that resident 13's call light was not working. *She instructed staff to give the call light assigned to room [ROOM NUMBER] to resident 13. *Based on call light audits, resident 13's call light potentially stopped working on 3/29/24. *Resident 13 was still using the call light assigned to room [ROOM NUMBER]. *She could reassign room numbers in the call light system computer program so that each resident's call light would match their room number. -However, the call light system computer program was not reliable and would crash each time she reassigned a room number. -That caused the entire call light system to malfunction and turn off. *She explained that if she had a list of 10 resident call lights to reassign, the program would crash and restart 10 times. -That caused residents and staff to become upset and stressed because the call light system would be nonfunctioning for an uncertain amount of time. *She did not know which company provided the call light system computer software. -At one point, they had a computer programmer examine their call light computer, but they were unable to fix it. *She confirmed there was no regular preventative maintenance for the resident's call lights. (continued on next page)

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	04/25/2024

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*After the malfunctioning call light incident with resident 13, she conducted a facility-wide audit from 4/3/24 to 4/5/24. -She replaced some call lights because they were not working properly. *Staff contacted her directly if they noticed a resident's call light button was broken, and she would instruct them what to do, or she would fix it herself. *Sometimes, staff reported a malfunctioning call light button in the maintenance request book. Interview on 4/25/24 at 10:19 a.m. with maintenance director D regarding the call lights revealed: *They did not have a preventative maintenance program for the call lights. *If a call light was malfunctioning, the staff informed him verbally and he would fix it right away. *He replaced the batteries in the call lights. Review of resident 13's call light audit report from 2/24/24 to 4/24/24 revealed: *She had been using a call light with the Remote ID of 38-5-100. *A Low Battery signal was transmitted on 3/28/24 at 5:30 p.m. *The resident's call light stopped functioning on 3/29/24 around 7:00 p.m. *The resident was given a different call light with the Remote ID of 38-4-251. -She first used that call light on 3/31/24 at 2:24 p.m. 3. Review of the provider's Maintenance Requisition from 12/15/23 through 4/22/24 revealed: *12/15/23, 107 call light not working. That request was not recorded as having been completed. *12/17/23, 119 call light unhooked. That request was not recorded as having been completed. *4/19/24, Rm [Room] 202 BR [bathroom] call light doesn't work. Review of the provider's revised 4/24/24 Call Light policy revealed: *There was no procedure on what staff were expected to do if a call light was malfunctioning. *There was no description of regular preventative maintenance checks for the call lights.