STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435071	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home	**129 W HWY 12 , WEBSTER, South Dakota, 57274**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
=0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/13/26 through 4/15/26. Bethesda Home was found not in compliance with the following requirements: F552, F641, F658, and F761. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/13/26 through 4/15/26. Areas surveyed included quality of care/treatment related to urinary tract infections and activities and meal preferences, resident abuse related to verbal abuse, and nursing services related to missing fentanyl patches. Bethesda Home was found not in compliance with the following requirement: F761.	F0000		
=0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.	F0552	F0552 1. On 4/15/26 all medications for Residents #1, #12 and #25 were reviewed. Residents/resident representatives of #1, #12, and #25 were contacted by facility staff to provide education and receive informed consent. Licensed staff members reviewed potential side effects, alternatives to medication, risks versus benefits, right to refuse treatment, the need for continued use, and that consent can be withdrawn at any time. 2. All residents have the potential to be affected a. All residents' charts were reviewed. b. Residents/resident representatives that have active orders for psychotropic medication were educated on potential side effects, alternatives to medications, risks versus benefits, right to refuse treatment, the need for continued use and that consent can be withdrawn at any time in language that they can understand, with informed consent received.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Baumgarn	CEO	05/11/2026

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F0552 SS = E	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or the resident's representative of the risks versus benefits of medications or of alternative treatments to make an informed decision for the consent for the use of psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) before they were administered to three of three sampled residents (1, 12, and 25). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed that he was admitted to the facility on 4/3/25. His 2/11/26 Brief Interview Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depression (mood disorder characterized by persistent, severe feelings of sadness, worthlessness, and a lack of interest in previously enjoyed activities for at least two weeks), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and a psychotic disorder with delusions (false beliefs and distorted views of reality). On 2/19/26, resident 1's psychiatric provider ordered to decrease his "Seroquel to 12.5 mg BID and 50mg at HS for psychosis and physically aggressive behaviors" and to "Start Seroquel [an antipsychotic medication] 12.5 mg [milligram] BID [twice a day] PRN [as needed] for 14 days." A 2/19/26 nurse's progress note indicated resident 1's representative was notified of the psychiatric provider's new orders for Seroquel. There was no documentation that resident 1 or his representative was informed of the indication for the medication change, the risks versus benefits of the medication, or alternative treatments to the medication. 2. Review of resident 12's EMR revealed that she was admitted to the facility on 2/25/26. Her 3/16/26 BIMS assessment score was 10, which indicated her cognition was moderately impaired. Her diagnoses included Neurocognitive disorder (a decline in cognitive functions like memory, attention, and language due to brain damage) with Lewy bodies	F0552	c. New process was implemented on 4/15/26 to ensure documentation of education provided to residents/resident representatives with informed consent received prior to implementation of new psychotropic medication or prior to increased dose of current medication. This is to include all new admissions. d. Education provided to all nurses on 5/4/26 and 5/5/26 on new process for psychotropic medications. 3. Audits will be completed, including current medications, informed consent, proper notification and proper documentation. DON or designee will complete audits for five residents weekly for four weeks and monthly for three months. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	05/15/26

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F0552 SS = E	Continued from page 2 (abnormal clumps of protein that build within nerve cells) with hallucinations (to see, hear, smell, taste or touch something that is not there)/psychiatric disturbances, Auditory hallucinations, Dementia (a group of symptoms affecting memory, thinking, and social abilities), and Post-Traumatic Stress Disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening or traumatic events). Resident 12 had a 2/25/26 physician's order for Olanzapine (an antipsychotic) 15 mg tablet to be taken once daily by mouth. There was no documentation that indicated the staff provided information to resident 12 or her representative regarding resident 12's psychotropic medication Olanzapine. Her 2/26/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) identified a problem area: "ADLs [activities of daily living] Functional Status/Rehabilitation Potential" A goal stated that the "Resident will remain free of adverse side effects of medications while maintaining current participation in ADL task.", with an intervention of "Receives psychotropic medication as directed, see eMAR [electronic medication administration record]. Monitor for effectiveness of the medication and side effects with MD [medical doctor] updated when [they are] noted. Pharmacy reviews [resident 12's] medications monthly. Monitor for increase in behaviors, changes in overall physical ability, notify MD when [they are] noted." 3. Interview on 4/15/26 at 1:57 p.m. registered nurse (RN) manager/infection preventionist (IP) C revealed she was responsible for keeping track of the residents' psychotropic medications and contacting and updating resident representatives of residents' medications changes. She indicated she reviewed psychotropic medications when residents were admitted to the facility and when residents' medication orders were changed. She educated residents and their representatives on an individual basis with psychotropic medication changes. She indicated that informed consents regarding psychotropic medications and their risks versus benefits were obtained verbally from residents or the resident's representative, and the facility did not use a written informed consent form. 4. Review of resident 25's EMR revealed that he was admitted to the facility on 10/23/25. His BIMS assessment score was 2, which indicated his cognition was severely impaired. His diagnoses included dementia with agitation and insomnia (a	F0552		

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=0552 SS = E	Continued from page 3 sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and being unable to return to sleep). Resident 25 was prescribed quetiapine (an antipsychotic medication) 12.5 mg (milligrams) to be administered at bedtime when he was admitted to the facility. On 10/24/25, a nurse's progress note indicated that the resident's representative was contacted by phone by registered nurse RN manager/IP C, and they discussed whether resident 25 should receive psychiatry services for his dementia. The resident representative agreed that resident 25 should receive psychiatry services and signed the consent forms for those services. A referral for the resident to receive psychiatry services was sent to resident 25's physician that same day (10/24/25). There was a 10/29/25 physician's order for trazodone (an antidepressant medication) 50 mg tablet to be administered at bedtime for insomnia. RN manager/IP C notified resident 25's representative, by phone, of the physician's new medication order. The progress note did not indicate that the representative gave their informed consent for resident 25 to be administered that medication or that education regarding the risks versus benefits of that medication was provided by RN manager/IP C. There was no documentation of written consent in Resident 25's EMR. There was a11/3/25 physician order for resident 25 to be administered an additional dose of quetiapine 6.25 mg, one time a day PRN (as needed) for his agitation. There was no documentation in resident 25's EMR indicating that resident 25's representative was notified and gave their informed consent for the additional antipsychotic medication, that education regarding the risks versus benefits of the medication was provided, or that written consent was obtained. There was an 11/6/25 physician's order to change the administration of resident 25's quetiapine from 12.5 mg at bedtime to 12.5 mg three times daily, discontinue the additional 6.25 mg PRN dose, and start Celexa (an antidepressant medication) at 10 mg daily for resident 25's mood disturbance. RN manager/IP C notified resident 25's representative by phone of the physician's new medication order. The progress note did not indicate that education on the risks versus benefits of the new antidepressant	F0552		

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=0552 SS = E	Continued from page 4 medication was provided, or that written consent for the changes in medication and dosage was obtained. On 11/8/25, a nurse's progress note indicated that resident 25's representative and family member visited and informed RN K that resident 25 was snowed [heavily sedated] and was upset about the medication changes. The family stated that the 12.5 mg dose of quetiapine being administered three times a day was like a "chemical restraint" and asked the physician to reduce the quetiapine to 6.25 mg twice daily. RN K contacted the physician immediately, and the physician ordered a reduction in resident 25's quetiapine to 6.25 mg twice daily. The physician also ordered an additional 6.25 mg dose to be given once daily as needed for resident 25 when increased agitation occurred. Resident 25's representative was satisfied with those medication orders. On 11/9/25, resident 25's representative called and spoke with licensed practical nurse (LPN) L, requesting that resident 25's Celexa be held and that she would visit with RN manager/IP C on 11/10/25 to discuss the request. Resident 25's representative wanted resident 25 to be off psychotropic medications and believed resident 25's behaviors were related to chronic pain. Resident 25's Celexa was discontinued by the physician on 11/13/25 at resident 25's representative's request. On 1/22/26, resident 25 received a physician order to change his quetiapine to 6.25 mg twice daily PRN for 14 days. RN manager/IP C notified resident 25's representative by phone of the new order. Resident 25's quetiapine 6.25 mg PRN medication was discontinued on 2/5/26. His 2/3/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) identified a problem area: "The resident requires assistance with activities of daily living (ADLs) throughout the day to ensure his needs are met as he has a diagnosis of dementia." A goal stated that the "Resident will remain free of adverse side effects of medications while maintaining current participation in ADL tasks", with an intervention of "Administer medication as ordered and monitor for side effects." The 2/3/26 care plan also identified a problem area	F0552		

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F0552 SS = E	Continued from page 5 of "Mood, Behavior, and Sleep" with a goal to "Adjust to the nursing home without increased signs and symptoms of anxiety or depression." The interventions included "Nursing to follow up on all physician recommendations for medication management", "Nursing will monitor for effectiveness of mood, behavior, and sleep medications and report any concerns to the provider", and if needed, "A referral will be made to psychiatry for added medication management." 5. Interview on 4/15/26 at 1:57 p.m. with RN manager/IP C revealed that she was responsible for keeping track of residents' psychotropic medications, contacting residents' families, and updating residents' representatives regarding medication changes and new medication orders from physicians. The residents' medications were reviewed and the side effects were discussed with the residents and their representatives upon admission to the facility. She educated the resident or the resident's representative about the psychotropic medication(s) on an individual basis. RN manager/IP C stated that progress notes documenting medication changes, new medication orders, and family/resident representatives' notifications were recorded in the resident's EMR, but that the notes did not include specific details about the risk-versus-benefit information provided to the resident or the resident's representative regarding the resident's psychotropic medications. RN manager/IP C stated that progress notes documenting medication changes, new medication orders, and family notifications were recorded in the resident's EMR, but that the notes did not include specific details about the risk-versus-benefit information provided to the resident or the resident representative regarding the resident's psychotropic medications. RN manager/IP C indicated that residents who were admitted to the facility while taking psychotropic medications, or were admitted before they started a psychotropic medication, did not have written informed consent forms obtained from the resident or the resident's representatives. The informed consents were obtained verbally by staff from residents or residents' representatives.	F0552		

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F0552 SS = E	Continued from page 6 RN manager/IP C acknowledged that there was no documentation in resident 25's EMR to indicate information was provided to his representative, that written informed consent forms were obtained for every medication change, or before starting him on a new psychotropic medication, and that his care plan did not address the risks versus the benefits of the psychotropic medications. 6. Interview on 4/15/26 at 2:57 p.m. with administrator A revealed that she believed the facility's process for educating and obtaining consent from residents or resident representatives regarding the use or initiation of a psychotropic medication was adequate. She stated that RN manager/IP C was "diligent" in notifying families or resident representatives of residents' medication changes and new medication orders, obtaining verbal consent for the use or initiation of psychotropic medications, and documenting the information in the residents' EMR. Administrator A acknowledged that the facility did not use a written informed consent form for residents taking psychotropic medications, which outlined the risks versus benefits and alternative treatments. She was unaware that documentation of the risks versus benefits reviewed with the resident or the resident's representative should be in the resident's EMR. She expected RN manager/IP C and all nurses to discuss the risks and benefits of medications, the reason a medication was started, or any medication dose change with the resident or the resident's representative, and to document those actions in the resident's EMR. 7. Review of the provider's 2/13/26 Psychotropic Medication policy found that "Psychotropic medications will only be used when medically necessary, after non-pharmacological interventions have been attempted and documented, unless contraindicated," and that "All psychotropic medications require dose, frequency, duration, and a clear indication for use." "Informed consent must be obtained from the resident or the responsible party," and "Written consent or other documentation is acceptable." "Residents have the right to be informed of	F0552		

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F0552 SS = E	Continued from page 7 treatment options," and "To ensure the safe, appropriate, and clinically justified use of psychotropic medications in accordance with CMS regulations and applicable state requirements while promoting residents' rights, safety, and quality of life."	F0552		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025	F0641	F0641 1. Resident #1 PASRR ARD date 4/10/25 was corrected on 4/29/26, PASRR ARD date 11/14/25 was corrected on 4/15/26. Resident #12 diagnoses corrected on ARD from 3/4/26 to include PTSD on 4/29/26. 2. All residents have the potential to be affected. a. All residents' PASRR's were reviewed with corrections made as necessary. b. All residents' MDS section I will be reviewed with corrections made as necessary. c. PASRR outcome guide was printed and is now being utilized as of 4/15/26. d. Section A was thoroughly read and reviewed by MDS coordinator and SSD. e. SSD will participate in PASRR education on 5/13/26. f. Section I thoroughly read and reviewed by MDS coordinator. g. MDS Coordinator enrolled in AAPACN course for further education. 3. MDS Coordinator or designee will complete audits for five residents weekly for four weeks and monthly for three months to ensure MDS accuracy. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	05/29/26

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F0641 SS = D	Continued from page 8 review, the provider failed to ensure one of one sampled residents' (1) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the area of PASARR, and one of one sampled residents' (12) MDS assessment was accurately coded for the area of active diagnoses. Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed he was admitted to the facility on 4/3/25. His 2/11/26 Brief Interview of Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depression, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and a psychotic disorder with delusions (false beliefs and distorted views of reality). Resident 1's 4/10/25 comprehensive admission and his 11/14/25 comprehensive MDS Assessment, section A (PASRR) under Preadmission Screening and Resident Review (PASRR) section did not have the Level II PASRR at A1500 marked as a yes. Resident 1's 4/12/17 Level I PASRR review was completed when he was admitted to a different facility. That Level I PASRR was sent for a Level II determination and was approved for a long-term care stay of 30 days or less. His 5/11/17 Level II PASRR approved him for a 60-day long-term care stay, and his 7/26/17 Level II PASRR determined he was approved for a long-term-care stay for an unlimited amount of time. 2. Interview and EMR review on 4/15/26 at 2:16 p.m. with MDS coordinator D confirmed resident 1 did have a mental health diagnosis of major depressive disorder. MDS coordinator D had indicated in his MDS assessments that he did not have a Level II PASRR. She further indicated that she had made a "mistake" by indicating he did not have a Level II PASRR. 3. Review of the 2025 South Dakota PASRR Level 1 and Level II PASRR Outcomes instructions revealed that when a Level II PASRR was approved for a long-term-care stay, the MDS was to be completed	F0641		

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F0641 SS = D	Continued from page 9 to indicate that resident had a Level II PASRR. 4. Review of resident 12's EMR revealed she was admitted to the facility on 2/25/26 and had a diagnosis of post-traumatic stress disorder (PTSD). Her 3/4/26 admission MDS Assessment, section I (active diagnoses) under Psychiatric/Mood Disorder did not have the diagnosis I6100 Post Traumatic Stress Disorder marked. 5. Interview and EMR review on 4/15/26 at 2:39 p.m. with MDS Coordinator D revealed she acknowledged that resident 12 had a diagnosis of PTSD upon admission to the facility on 2/25/26. She confirmed resident 12 had received psychiatric services before she was admitted to the facility, and that resident 12 received psychiatric services on 3/26/26 with a new provider. She reviewed resident 12's admission MDS assessment, section I and acknowledged that I1600 Post Traumatic Stress Disorder was not marked. When completing the resident's MDS assessment she referred to the resident's information that was sent with them to the facility when they were admitted, which included diagnosis, medication order's and physician progress notes. She did not consider resident 12's PTSD an active diagnosis since the resident did not have any medications prescribed for PTSD. She referenced the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 to complete the residents' MDS assessments. 6. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed section A, item A1500 revealed "Code 1, yes if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition". Section I, Page I1 and I2, "Steps for Assessment: 1. Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available."	F0641		

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F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, policy review, and review of budesonide (a steroid used to treat lung inflammation) manufacturer's instructions the provider failed to ensure staff administered the budesonide nebulizer (a device that converts liquid medication into an inhalable mist) according to the manufacturer's instructions for one of one sampled resident (7) who developed thrush (a yeast infection in the mouth and throat). Findings include: 1. Observation on 4/13/26 at 2:44 p.m. of resident 7's room revealed there was a nebulizer machine and mask on his bedside table between his bed and recliner. The nebulizer mask was assembled and sitting on the nebulizer machine. 2. Observation and interview on 4/14/26 at 8:29 a.m. with resident 7 in his room revealed he was admitted to the facility after he was in the hospital for shortness of breath. The nurses and certified medication aides (CMAs) administered a nebulizer treatment to him two times a day, once in the morning and once at bedtime. The nurse or CMA would set up his nebulizer and often left the room while he was taking the nebulizer treatment. Sometimes the nurse or CMA returned to his room and rinsed out the nebulizer mask, sometimes they did not. When he finished with his treatment he would place the nebulizer mask on top of the nebulizer machine, which was on his bedside table. The medication chamber attached to the nebulizer mask appeared hazy with an unknown substance. The staff did not ask him to rinse out his mouth after he received his nebulizer treatments and he did not know he should rinse out his mouth after his nebulizer treatments. He knew one of his nebulizer medications caused him to get thrush sometimes, and he would take a lozenge (a medicated tablet to be held in the mouth to dissolve) to treat it.	F0658	F0658 1. Resident #7 is unable to self-administer nebulizer treatments. All nurses and medication aids were re-educated to supervise resident during nebulizer treatments and ensure resident rinses his mouth after his Budesonide treatments, along with following the manufacturer instructions and facility protocol to maintain integrity of nebulizer equipment. 2. All residents with active orders for nebulizer treatments have the potential to be affected. a. Charts reviewed for all residents with active orders for nebulizer treatments with re-education provided for all nurses and medication aids to supervise residents during their treatments. b. Charts reviewed for all residents with active orders for Budesonide nebulizer treatment with education provided for all nurses and medication aids to ensure residents rinse their mouths out after the treatments, along with following the manufacturer instructions and facility protocol to maintain integrity of nebulizer equipment. c. Policy reviewed and revised on 5/1/26 with education provided to all nurses and medication aids on 5/4/26, 5/5/26, and 5/12/26. 3. DON or designee will audit five nebulizer treatments weekly for four weeks and monthly for three months. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	05/15/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435071	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

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F0658 SS = D	Continued from page 11 3. Review of resident 7's electronic medical record (EMR) revealed he was admitted to the facility on 10/13/25, had a 1/30/26 Brief Interview for Mental Status (BIMS) assessment score of 12, which indicated his cognition was moderately impaired, and his diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and can make it difficult to breathe) (COPD). His 4/14/26 care plan indicated he had his own teeth and to "assist with oral cares in am [a.m.] and pm. [p.m.]. He had a 10/13/25 physician's order for clotrimazole troches (a medication to treat thrush) lozenge 10 milligrams (mg) one time a day at bedtime for thrush and a 11/5/25 physician's order for a budesonide nebulizer 0.5 mg/ 2 ml (milliliters) two times a day with instructions that stated, "Make sure mouth is being rinsed with water after to help prevent oral thrush". On 10/30/25 resident 7's physician was notified by registered nurse (RN) M that resident 7 was "requesting that he get 5 clotrimazole troches every day because he feels like he has oral thrush. No white spots noted in [his] mouth but [the] resident states that he has had it twice before and 'this is exactly what it was before when I had it'." On 10/30/25 Resident 7's physician ordered clotrimazole troche five times per day for two weeks for thrush. 4. Interview on 4/15/26 at 10:58 a.m. with RN G revealed when she administered a resident's nebulizer she would set up the nebulizer treatment, remained in the room with the resident, and when the treatment was completed, she shook out the excess liquid from the nebulizer medication chamber and placed the mask in a vented storage bag to dry. A resident who received steroid medications such as budesonide should be encouraged to rinse their mouth after that nebulizer treatment. 5. Interview on 4/15/26 at 4:23 p.m. with director of nursing (DON) B and RN manager/infection preventionist (IP) C revealed DON B expected that after a resident's nebulizer was completed, the nebulizer mask would be rinsed out. RN manager/IP C corrected DON B and stated the provider's policy had changed and any excess liquid from the nebulizer treatment was to be shaken out of the nebulizer medication chamber and the nebulizer	F0658		

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=0658 SS = D	Continued from page 12 mask was to be placed in a vented storage bag to dry. DON B expected a resident's mouth to be rinsed if the nebulizer treatment was a steroid such as budesonide and if the nebulizer mask was soiled it was to be rinsed out with distilled water. She was not aware the budesonide nebulizer manufacturer's instructions were to wash the nebulizer mask with a mild detergent after each administration of the medication. 6. Review of the provider's 8/11/23 Nebulizer Administration policy revealed that if the resident's "nebulizer is to be reused, discard any excess solution and place in vented storage bag" and if "residue is noted, discard nebulizer and replace with new or rinse with sterile water and allow to air dry in a vented bag. Do not rinse with tap water." 7. Review of the 2/13/23 budesonide manufacturer's instructions revealed the "incidence of candidiasis [yeast infection] can generally be held to a minimum by having patients rinse their mouths out with water after each nebulization treatment." "The nebulizer chamber should be cleaned after every administration. Wash the nebulizer chamber and mouthpiece of face mask with hot tap water using a mild detergent. Rinse it well and dry by connecting the nebulizer chamber to the compressor or air inlet."	F0658		
=0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	F0761 1. Investigation initiated immediately following notification of missing Fentanyl patch on 3/23/26. Nurse K did not work any shifts following completion of investigation. Nurse K gave voluntary resignation on 3/25/26 with the facility accepting the resignation effective immediately. Resident #35 interviewed with no complaints of pain and happy with her care. 2. All residents have the potential to be affected a. Facility protocol reviewed with education provided to all nurses regarding Fentanyl patch administration on 3/26/26.	

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F0761 SS = D	Continued from page 13 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review the provider failed to ensure drugs and biologicals were labeled, securely stored, and discarded regarding: *One of one fentanyl patch (a medications with risk for abuse and addiction) pain medication for resident 35 that was not administered or securely stored after it was removed from the double locked storage on medication cart C by registered nurse (RN) K. *One of one sampled resident's (24) Vicks Vaporub, Gold Bond Medicated Powder, Blu-Emu Cream (a pain-relieving cream) Voltaren 1% cream (a pain-relieving cream), and seawater nasal spray that were not securely stored to prevent other residents from accessing them. *Medications with shortened expiration dates (medications that, after opening, expire before the manufacturer's expiration date) that were not labeled and disposed of after being outdated for two of two sampled residents (13 and 18), latanoprost eye drops in two of three observed medication carts. *Expired insulin syringes that were not disposed of and available for use in three of three observed medication carts and one of one observed medication room. Findings include: 1. Review of the provider's 3/23/26 SD DOH FRI revealed that director of nursing (DON) B was notified by RN K that there was a missing (not accounted for) fentanyl patch at 9:05 a.m. on 3/23/26. RN K stated she placed the fentanyl patch on top of a Tegaderm (clear adhesive dressing) to carry into resident 35's room, and when she was going to place the fentanyl patch on resident 35, she	F0761	3. DON or designee will complete audits for narcotic patch administration; including preparation, handling, placement and wasting of narcotic patches. Audits will include five residents weekly for four weeks and monthly for three months to ensure proper patch handling Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly. 1. Resident #24's medications have been placed in lock box to ensure medications are not accessible to other residents. 2. All residents have the potential to be affected a. All charts were reviewed and residents with orders for bedside medications identified. Lock boxes placed in rooms to securely store bedside medications. b. Education provided to all nursing staff on 5/4/26 and 5/5/26 regarding safe storage of bedside medications and new protocol. 3. DON or designee will complete five audits weekly for four weeks and monthly for three months to ensure medications are securely stored in the lock box. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly. 1. The Latanoprost for residents #13 and #18 was removed and replaced on 4/14/2026 and dated upon opening. 2. All residents have the potential to be affected. a. Medication room and medication carts were inspected with all shortened expiration date medications that were not dated removed with new medications received and dated upon opening.	

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=0761 SS = D	Continued from page 14 did not have the fentanyl patch. RN K reported to DON B that she had searched resident 35's room including the resident's chair, the garbage can next to her chair, and the floor. RN K then went back into the hallway, looked on the floor in the hallway, checked the bottom of her shoes, and the garbage can on the medication cart, and RN K was unable to find the fentanyl patch. After director of nursing (DON) B was notified of the missing fentanyl patch, she notified additional staff members to assist in looking for the missing fentanyl patch. Those staff members looked in the laundry room including the washer, dryer, lint traps, and the dirty laundry from hallway C. The drawers were removed from medication cart C. Housekeeping staff searched the hallway, resident 35's room, and the vacuum. Maintenance took the vacuum apart to be sure the fentanyl patch was not in a vacuum hose. DON B asked RN K if she had the fentanyl patch in her hands when she went into resident 35's room and RN K stated she thought she did. She had taken the patch out of the locked controlled substance drawer in medication cart C, wrote her name and initials on the fentanyl patch, and laid it on the Tegaderm package. She then picked up the Tegaderm, fentanyl patch, resident 35's other medications, and her Voltaren cream, brought them into resident 35's room and placed them on her bedside table. When RN K was going to place the fentanyl patch on resident 35 RN K noticed she had written on the plastic piece that was attached to the adhesive part of the fentanyl patch, and that the patch was not there. RN K stated she had gone into medication cart C, taken out another fentanyl patch, and placed it on resident 35. DON B asked RN K why she did not notify her or one of the other managers of the missing fentanyl patch before 9:05 a.m., and RN K stated she was waiting until DON B arrived at the facility to notify her. When DON B looked through the garbage, all the packaging pieces for one of the fentanyl patches were found, but only a small piece of packaging from the top and the side of the other fentanyl patch was found in the garbage. The piece that RN K stated she had written her name and date on was not found. DON B, RN Manager/infection preventionist (IP) C, and RN/staff development coordinator (SDC) H watched the facility's 3/23/26 camera footage to	F0761	b. Facility reviewed all medications with shortened expiration dates with consultant pharmacist. Pharmacy to apply labels specifying the number of days before expiration after opening on all medications with shortened expiration dates. Pharmacy also to provide list of medications that this is applicable to and how long until they expire once opened. c. Education provided on 5/4 and 5/5 to all nurses and UMAs regarding medications with shortened expiration dates and dating upon opening. 3. DON or designee will complete five audits weekly of medications with shortened expiration dates to ensure they were labeled upon opening and disposed of properly per manufacturer guidelines. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly. 1. Resident #6 received Torsemide at 1432 on 4/14/26, which was within allotted time for medication administration. 2. All residents have the potential to be affected. a. Education provided to all nurses and UMA's on 5/4/26 and 5/5/26 to ensure resident is available prior to prepping medications, as once prepped they are not to be kept or stored to decrease risk of medication error. 3. DON or designee will complete five audits weekly for four weeks and monthly for three months to ensure medications are securely stored in the lock box. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	

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F0761 SS = D	Continued from page 15 determine a timeline and to assist in the search for the missing fentanyl patch. Medication cart C was placed between two resident rooms in hallway C. At 6:35 a.m. RN K unlocked and opened the controlled medication drawer in medication cart C and removed a fentanyl patch from that drawer. At 6:37 a.m. RN K entered resident 7's room, and exited that room at 6:39 a.m. RN K stood at medication cart C until "approximately" 6:45 a.m. She then returned to resident 7's with certified nursing assistant (CNA) E. At 6:46 a.m. RN K exited that resident's room, grabbed the items off the top of medication cart C, and entered resident 35's room. At 6:48 a.m. RN K exited resident 35's room, looked on the top of medication cart C, then looked on the floor beside the cart. She then spoke with CNA E and she and CNA E entered resident 35's room. At 6:51 a.m. RN K exited resident 35's room, checked the bottoms of her shoes, and the garbage can on the side of medication cart C. At "approximately" 6:52 a.m. RN K went back into resident 35's room, CNA E exited the room, and RN K remained in resident 35's room until 6:57 a.m. At 6:57 a.m. RN K exited resident 35's room with garbage bags. She took those garbage bags into the medication room, "put gloves on and got down on the floor to look through the garbage bag." At 7:00 a.m. RN K exited the medication room and went down the A hallway and notified the other RN on duty. RN K returned to hallway C at 7:03 a.m. She took another fentanyl patch out of medication cart C and showed the patch to other staff members. At 7:08 a.m. RN K took the second fentanyl patch that she had removed from medication cart C into resident 35's room and "applies [the] new patch to resident [35]." The missing fentanyl patch was not located. RN K resigned from her position on 3/25/26. 2. Review of resident 35's electronic medical record (EMR) revealed she admitted to the facility on 3/10/26 and discharged to her home on 3/25/26. She had a 3/11/26 physician's order for a fentanyl 12 micrograms/hour patch to be applied to her skin every 72 hours and to remove the old fentanyl patch before the new one was applied. Resident 35's medication administration record (MAR) indicated on3/23/26 that RN K removed the old fentanyl patch and applied a new patch on resident 35's skin.	F0761	1. Expired syringes were removed from medication room and carts on 4/14/26. 2. All residents have potential to be affected. a. Medication room and medication carts were inspected with no other expired supplies found. b. New protocol in place to ensure supplies are removed upon expiration date. c. Education provided to all nurses, medication aids, and ward clerk on 04/29/26, 5/4/26, and 5/5/26. 3. DON or designee will complete five audits of med room and med carts weekly for four weeks and monthly for three months to ensure supplies are not outdated Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	05/29/26

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F0761 SS = D	Continued from page 16 3. Review of resident 35's Controlled Drug Record for Patches indicated she had received ten fentanyl patches from the pharmacy. On that form, the nurse was to document the date, time, if a patch was wasted, and to sign it with an additional nurse. Above the signature columns it stated, "Signature (Denotes Patch Applied/Wasted)/ 2nd Nurse Signature". On 3/23/26 at 7:00 a.m. patch number 5 was documented as one patch missing and signed by RN K and RN J. On 3/23/26 at 7:00 a.m. patch number six was documented as one patch wasted and signed by RN K and RN J. The missing fentanyl patch was documented on the Controlled Drug Record for Patches by RN K and RN J after the fentanyl patch was removed from the controlled medication drawer, to be placed on resident 35, and was discovered to be missing. 4. Review of RN K's education following the missing fentanyl patch revealed, "No medications should be prepped [prepared] and left on [the] top of [the] med [medication] cart in [the] hallway. Meds [medications] should be prepped right before med administration. Narcotics should be handled carefully. Fentanyl patch [es] should be carried in [the] package to [the] residents [resident's] room as it should be handled with gloves d/t [due to] potency and risk for exposure. DON, nurse manager, SDC, CEO [chief executive officer] should be notified immediately to ensure thorough search is completed." 5. Interview on 4/15/26 at 11:07 a.m. with RN J revealed she was working on 3/23/26 when the above fentanyl patch went missing. RN K had notified her that the fentanyl patch was missing. RN K and CNA E looked for the fentanyl patch, but it was not found. RN J verified she had signed the Controlled Drug Record for Patches when the second patch was removed from the locked compartment in medication cart C to be placed on resident 35 after the old patch was removed. 6. Interview on 4/15/26 at 11:19 a.m. with CNA E revealed she was working in hallway C on 3/23/36 when resident 35's fentanyl patch went missing. RN K notified her that the fentanyl patch was missing early during their shift, approximately between 6:00 a.m. and 7:00 a.m. She looked for the fentanyl patch with RN K in the garbage bags, in the medication cart, on their shoes, and "all over" hallway C, but they did not find it.	F0761		

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F0761 SS = D	Continued from page 17 7. Observation on 4/13/26 at 4:42 p.m. of resident 24's room revealed his door was open and there was a container of Vicks Vaporub medicated ointment on his over the bed table. 8. Observation and interview on 4/15/26 at 8:54 a.m. with resident 24 in his room revealed there was bottle of seawater nasal spray on his bedside table, Vicks medicated ointment and Blu-Emu cream on his over the bed table, Gold Bond medicated powder on the table behind his door. Resident 24 stated he used the Vicks in his nose when he was congested but had not used that for "quite a while". He used the seawater nasal spray in his nose, and the bottle was "almost empty". Resident 24 stated the medications were left in his room for him to use when he needed them. 9. Review of resident 24's EMR revealed he admitted to the facility on 8/1/24. He had a 1/22/26 Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated his cognition was intact. His physician's orders included an 8/2/24 order for Voltaren cream 1% to be applied to his left thumb two times a day as needed, and he could keep it at his bedside. An 8/2/24 order for Blu- emu cream that could be applied up to four times per day to feet as needed, and he could keep it at his bedside. An 11/14/25 order for Vicks Vaporub to be applied to his feet as needed for pain, and he could keep it at his bedside. A 2/2/26 order for nasal moisturizing spray to use as needed and he could keep it at his bedside. A 2/2/26 order for "Bedside med assessment: Vicks, Voltaren cream 1%, Blu-emu cream, and Gold Bond powder, Costco Fiber Tablet/Gummies, Vaseline, and nasal moisturizing spray. Once A Day on Fri [Friday]". Resident 24's 1/10/25 Self-Administration of Medications assessment indicated he could safely administer "Pills, creams and ointments with set up provided by nursing staff' and that the self-administered medications were stored in the nursing medication cart. His 4/14/26 care plan indicated a goal of "Resident will continue to use and store medication appropriately" with the approach of "Has order for bedside and self administration of medications. See physician's orders. Nursing staff monitors usage and storage with MD [medical doctor] updated for	F0761		

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=0761 SS = D	Continued from page 18 changes in ability/cognition noted." 10. Observation and interview on 4/14/26 at 1:40 p.m. with RN manager/infection IP C in the medication room revealed there was a plastic container of 100-unit insulin syringes with needles that outdated on 1/31/26. RN manager/IP C stated ward clerk N was responsible for ordering, stocking, and checking the supplies in the medication room for outdates weekly. 11. Interview and observation on 4/14/26 at 1:55 p.m. with RN manager/IP C of medication carts A, B and C revealed there was a paper medication cup in the top drawer of medication cart C labeled with two letters. RN G was the nurse who was administering medications from medication cart C on 4/14/26. RN manager/IP C verified there were two paper medication cups stacked on top of each other with a medication between the two medication cups and a resident's initials were written on the top medication cup in black ink. She stated the medications were prepared and left in medication cart C rather than being immediately administered to that resident. In the top drawer of medication cart C there were ten 100-unit insulin syringes with needles that outdated on 1/31/26. There was a bottle of resident 13's latanoprost eye drops (medication used to lower eye pressure related to glaucoma) that did not have a date when the medication was opened. RN manager/IP C verified there was no date to identify when the latanoprost eye drops were opened. She stated she did not expect the nurses to date the latanoprost eye drops when it was opened for administration. In medication cart B there were five 100-unit insulin syringes with needles that outdated on 1/31/26 and in medication cart A RN manager/IP C was observed removing an undisclosed amount of 100-unit insulin syringes with needles that outdated on 1/31/26. 12. Review of resident 6's EMR revealed she had a 4/13/26 physician's order for torsemide (a medication to decrease swelling) 80 mg two times a day at 8:00 a.m. and 2:00 p.m. 13. Review of resident 13's EMR revealed she had a 11/20/24 physician's order for latanoprost eye drops, one drop in both eyes daily at 8:00 p.m.	F0761		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home	**129 W HWY 12 , WEBSTER, South Dakota, 57274**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = D	Continued from page 19 14. Observation and interview on 4/14/26 of medication cart A with RN F revealed there was a bottle of resident 18's latanoprost eye drops that was not dated when it was opened for administration. RN F verified there was no date documented on the bottle or box that indicated when resident 18's latanoprost eye drops were opened for administration. 15. Review of resident 18's EMR revealed she had a 3/16/21 physician's order for latanoprost eye drops, one drop in both eyes daily at 7:30 p.m. 16. Interview on 4/15/26 at 10:58 a.m. with RN G revealed she had prepared resident 6's medication and placed it in the top drawer of medication cart C because after she prepared it she found out resident 6 was out of the facility for an appointment so she could not administer the medication to her. RN G stated she put the medication back in the medication cart between two paper medication cups, labeled the cup with resident 6's initials, and administered the medication to her when she returned from her appointment. RN G stated she did not prepare residents' medication ahead of their administration times routinely but sometimes if the residents were not available after she had prepared their medications, she would label them with their initials and lock them in the medication cart until that resident was available to have their medications administered to them. 17. Interview on 4/15/26 at 11:09 a.m. with RN J revealed she would use the drug reference book or call the pharmacy to determine if a medication had a shortened expiration date after it was opened. She was not aware that latanoprost eye drops had a shortened expiration date after they were opened. It was not her common practice to label eye drops when they were opened. She did not know when the latanoprost eye drops for residents 13 and 18 would expire since they were not labeled when they were opened. Ward clerk N was responsible for checking the outdates and rotating the medical supplies in the medication room. The nurse scheduled on the night shift was responsible for checking for outdated medications and supplies in the medication carts. 18. Interview, EMR review, and policy review on	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435071	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

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=0761 SS = D	Continued from page 20 4/15/26 at 4:23 p.m. with DON B revealed she investigated the missing fentanyl patch and reported the incident to the SD DOH. On 3/23/26 she entered the facility at about 8:50 p.m., when she was notified by RN K that there was a missing fentanyl patch. RN K told her that she was going to change resident 35's fentanyl patch and when she entered resident 35's room, the patch was not in the package. RN K stated she had taken the fentanyl patch out of its package to write on the fentanyl patch, but she had written on the plastic attached to the fentanyl patch and not the patch itself. She had watched the video footage on 3/23/26 and the camera that recorded hallway C was at the nurses' station, so the patch could not be seen on the footage due to its distance from medication cart C. After RN K removed the fentanyl patch from the locked compartment in medication cart C, she left the cart and entered resident 7's room. She exited resident 7's room and went into resident 35's room. After she went into resident 35's room, RN K went back into the hallway, looked on the top of medication cart C and picked up the garbage bag on the medication cart. DON B expected controlled medications such as fentanyl to be removed from the locked compartment in the medication cart and administered to the resident immediately. The nurse who administered the fentanyl patch to the resident, was to remove it from its packaging, write the nurse's name and the date on it and place it back into packaging before bringing the fentanyl patch into the resident's room to place it on the resident. If a fentanyl patch was missing, she expected to be notified immediately. DON B acknowledged the missing fentanyl patch could not be witnessed as having been wasted since it was not found. She stated that is why she had RN K and RN J document that it was missing on the Controlled Drug Record for Patches. The video footage could not be viewed because the saved format was unable to be opened, and the provider's camera system did not save video footage for that long of period. DON B stated she expected the medications with shortened expiration dates to be dated when they were opened. The pharmacy was supposed to attach a label on medications with shortened expiration dates to prompt the nurses to date those medications when opened and when they would expire, but the pharmacy was not doing that routinely. The staff who administered medications were not aware that there were other medications,	F0761		

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F0761 SS = D	Continued from page 21 other than insulin, that had shortened expiration dates after they were opened so they did not date them when they opened them. Medications were to be stored in a secure location to prevent the residents from accessing those medications. She was aware that resident 24 had medications in his room on his table and acknowledged that those medications were not stored securely which created the potential for other residents to have access to those medications. She acknowledged the self-administration of medications policy and resident 24's self-administration assessment indicated the medications were to be stored in the medication cart. She stated that the self-administration of medications policy was not considered when the bedside medications policy was initiated. Medications were not to be pre-prepared for administration to the residents, but at times the residents were not available after their medications were prepared, so the medications were placed in a medication cup with their initials written on the cup in the locked medication cart and were administered when that resident was available. She stated the nurses did that because otherwise they would need to waste the medications if the resident was at an appointment. DON B acknowledged there was the potential for a medication error when pre-prepared medications were stored in the medication cart. Ward Clerk N was responsible for checking outdated medications and supplies weekly. Every Friday, Saturday, and Sunday, the nurse scheduled to work the night shift was responsible for checking the medication carts for outdated medications and supplies. DON B acknowledged there were outdated insulin syringes in the medication room and all three medication carts that could have been used to administer a medication to a resident. 19. Review of the provider's 12/8/21 Narcotic [controlled] Medication policy revealed the provider "requires accountabilities for all controlled substances. All staff including licensed nurses and medication aids are responsible for narcotics given during their assignment." "Schedule II controlled substances [a fentanyl patch] are to be double locked." "When [a] discrepancy is noted [the] charge nurse if to notify DON/Administrator immediately." 20. Review of the provider's 4/15/25	F0761		

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F0761 SS = D	Continued from page 22 Self-Administration of Medications policy revealed, "Medications will be stored in [a] med [medication] cart and given to the resident at scheduled times for self-administration." 21. Review of the provider's 4/15/25 Shortened Expiration Medication policy revealed, "All medications with shortened expiration dates must be labeled upon opening or removal from refrigeration and used or discarded in accordance with manufacturer's guidelines." "Medications with shortened expiration dates include but are not limited to 1. Eye drops 2. Insulin 3. Injectables 4. Nasal sprays 5. Emergency inhalers." "Nursing staff are responsible for referencing expiration day calendar sheet for expiration dates." 22. Review of the August 2011 latanoprost eye drop manufacturer's instructions revealed, "Once a bottle is opened for use, it may be stored at room temperature… for 6 weeks." 23. Review of the provider's 4/30/25 Outdated Supplies policy revealed the provider was to "maintain a system to identify, remove and properly dispose of expired or outdated supplies to ensure resident safety". "Expired or damaged items shall never be used for resident care." "Each department shall conduct routine inspections of supply areas: i. Monthly at minimum or more frequently as indicated." "Expired or compromised supplies shall be: Removed immediately from active stock." 24. Review of the provider's 4/15/25 Medication Storage policy revealed, "All medications must be stored in locked compartments when not in use." "Controlled substances must be stored in a separately locked, permanently affixed compartment." "All medications must be clearly labeled with: i. Resident name ii. Medication name iii. Strength and dosage iv. Expiration date. Medications without proper labeling shall not be administered." 25. A policy regarding bedside medications was requested but was not provided by the end of the survey.	F0761		

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	435071	A. BUILDING B. WING	04/16/2026

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Bethesda Home	129 W HWY 12 , WEBSTER, South Dakota, 57274

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 4/16/26. Bethesda Home was found not in compliance with the following requirements: E004 and E030.	E0000		
E0004 SS = D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an	E0004	E0004 1. The emergency preparedness binder was reviewed in its entirety and updated on 04/28/26 to ensure all policies, procedures, contact lists, and facility-specific information is current and compliant. 2. All residents, staff and visitors have the potential to be affected. a. The facility implemented the requirement of the Emergency Preparedness Program to be reviewed and updated at least annually and/or following any significant event. Staff were educated on 04/16/26 and again on 05/04/26 and 05/05/26. The Administrator or designee is responsible for ensuring completion and documentation of the review. 3. The Administrator or designee will conduct audits of the Emergency Preparedness binder weekly for 4 weeks then monthly for 3 months. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	04/28/26

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable) 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 4 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 ·ogram participation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Baumgarn	CEO	05/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435071	A. BUILDING B. WING	04/16/2026

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E0004 SS = D	Continued from page 1 emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is NOT MET as evidenced by: A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 4/16/26. Bethesda Home was found not in compliance with the following requirement: E004. The Emergency Preparedness binder located in the administrator's office had not been updated annually in 2024 and 2025. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0004		
E0030 SS = D	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.	E0030	E0030 1. The facility has reviewed and updated all names and contact information within the Emergency Preparedness binder on 04/28/26, including but not limited to staff call lists, physicians, pharmacies, utilities, and local emergency contacts. 2. All residents, staff, and visitors have the potential to be affected. a. The facility has implemented a protocol requiring review and verification of all Emergency Preparedness contact information. Staff were educated on 04/16/26 and again on 05/04/26 and 05/05/26. The Administrator or designee is responsible for ensuring updates are completed and documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435071	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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E0030 SS = D	Continued from page 2 (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication	E0030	3. The Administrator or designee will conduct audits of Emergency Preparedness contact information weekly for 4 weeks then monthly for 3 months. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	04/28/26

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E0030 SS = D	Continued from page 3 plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is NOT MET as evidenced by: A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 4/16/26. Bethesda Home was found not in compliance with the following requirement: E030. The Emergency Preparedness binder located in the administrator's office did not contain a contact list for staff in the event of an emergency. A contact list was located in another binder in the administrator's	E0030		

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E0030 SS = D	Continued from page 4 office. Interview with the administrator at the time of the record review confirmed that finding. The deficiency could affect 100% of the building occupants.	E0030		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435071	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 4/16/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethesda Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K342 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0712 SS = F Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain fire drill training for staff (a minimum required number of fire drills were documented, a lack of variance in the timing of the quarterly fire drills was noted for the second and third shifts, and a lack of adequate response to the survey in-house fire drill). Findings include: 1. Record review on 4/16/26 at 9:45 a.m. and observation on 4/16/26 at 12:25 p.m. revealed the following: A total of 13 documented fire drills were found for 2025 held on a quarterly basis for a	K0712	K0712 1.The facility conducted one fire drill on 05/01/26, one fire drill on each shift on 05/04/26, and 05/05/26 to ensure staff are educated and trained in fire safety procedures. Documentation of the drills, including staff participation and any needed corrections, has been completed. 2.All residents, staff and visitors have the potential to be affected. a. The facility has implemented a plan to ensure fire drills are conducted at least quarterly at varying times on each shift or as needed. All staff will receive ongoing fire safety training during orientation and annually thereafter. The Administrator or designee is responsible for ensuring drills are conducted, staff participate, and documentation is completed. 3.The Administrator or designee will conduct fire drill audits and staff training for all three shifts weekly for 4 weeks then monthly for 3 months. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	05/15/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anne Baumgarn	CEO	05/07/2026

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Bethesda Home	**129 W HWY 12 , WEBSTER, South Dakota, 57274**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0712 SS = F Bldg. 01	Continued from page 1 three-shift staffing arrangement (one more than the minimum required to be held). Second shift (3:00 p.m. to 11:00 p.m.) drills were held on February 27, 2025 at 3:19 p.m., on May 30, 2025 at 4:00 p.m., on August 25, 2025 at 4:36 p.m., and on November 25, 2025 at 5:10 p.m. The times of the drills were not varied. Third shift (11:00 p.m. to 7:00 a.m.) drills were held on March 31, 2025 at 4:03 a.m., on June 30, 2025 at 11:07 p.m., on September 25, 2025 11:21 p.m., and on December 23, 2025 at 11:08 p.m. A single staff person responded to the fire drill location (initiated by a resident call light for room C10) and announced the fire over the walkie-talkie system two times (announcing three times is standard). Staff responding to the drill location with fire extinguishers did not know how to check the corridor door for heat (using the back of a hand to check the door first, then the door handle). The closest manual fire alarm pull station had a cover with a local alarm to deter residents from activating the fire alarm. The staff person responding to the simulated fire only lifted that alarmed cover and did not pull the manual station to activate the actual fire alarm. The corridor door for resident room C11 was not closed and latched. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiency could affect 100% of the building occupants.	K0712		
K0342 SS = D Bldg. 01	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain manual fire alarm pull stations with clear and unobstructed access for use in activating the fire alarm system at one of six	K0342	K0342 1.The obstruction to the fire alarm pull station was removed on 04/16/26, ensuring clear and unobstructed access to the device. Staff were re-educated on the importance of maintaining access to all fire alarm initiating devices. 2.All residents, staff, and visitors have the potential to be affected. a. All fire alarm pull stations throughout the facility were inspected to ensure they are clear, visible, and have unobstructed access to the device. Any identified issues were corrected. b. The facility has implemented routine environmental rounds to ensure all fire alarm initiating devices always remain unobstructed and accessible. Staff were educated on 04/16/26 and again on 05/04/26 and 05/05/26 not to place equipment, furniture, or other items in front of pull stations. The Maintenance Director or designee is responsible for ensuring compliance during routine safety rounds.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435071	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home	**129 W HWY 12 , WEBSTER, South Dakota, 57274**

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K0342 SS = D Bldg. 01	Continued from page 2 locations (west wing). Findings include: 1. Observation on 4/16/26 at 1:50 p.m. revealed the manual pull station for the fire alarm system located adjacent to the west wing exit door had two resident lifts kept directly in front of the pull station. The pull station had a local alarm cover (an acceptable device) installed on it which would also sound an alarm to deter residents from activating the fire alarm. Interview with the maintenance director at the time of the record review confirmed the lifts kept in front of the fire alarm pull station. The lifts were moved during the survey. The deficiency affected one of numerous requirements for the fire alarm system.	K0342	3. The Maintenance Director, or designee will conduct audits of fire alarm pull station accessibility weekly for 4 weeks then monthly for 3 months. Audit results will be documented and reported to the QAPI Committee. The QAPI Committee will review findings, trends, and ensure any identified issues are corrected promptly.	04/16/26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10706	A. BUILDING: _____ B. WING _____	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	129 W HWY 12 WEBSTER, SD 57274

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted on 4/13/26 through 4/16/26. Bethesda Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Anne Baumgarn

TITLE: CEO

(X6) DATE: 05/11/2026