	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
			A. BUILDING			с
		435096	B. WING		1	1/07/2024
iame of Pr	OVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	HOME SIOUX FALLS			001 SOUTH HOLLY AVENUE		
			S	IOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 000	INITIAL COMMENTS		F 000			
	with 42 CFR Part 483 for Long Term Care fa 11/5/24 through 11/7/2 Falls was found not in	h survey for compliance , Subpart B, requirements acilities was conducted from 24. Bethany Home Sioux a compliance with the s: F582, F623, F625, F657,				
	CFR Part 483, Subpa Term Care facilities w through 11/7/24. Area resident neglect and e Sioux Falls was found following requirement	elopement. Bethany Home I not in compliance with the s F600. overage/Liability Notice	F 582			
	writing, at the time of facility and when the f Medicaid of- (A) The items and ser nursing facility service for which the resident (B) Those other items facility offers and for charged, and the and services; and (ii) Inform each Medic changes are made to	aid-eligible resident, in admission to the nursing resident becomes eligible for rvices that are included in es under the State plan and				
		acility must inform each the time of admission, and				

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 12/09/2024 APPROVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1	IPLE CONSTRUCTION		(X3) DATE COMPL	
		435096	B. WING_		2	C 11/0))7/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				1901 SOUTH HOLLY AVENU	E		
BETHANY	HOME SIOUX FALLS			SIOUX FALLS, SD 57105			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 582	available in the facility services, including an covered under Medica facility's per diem rate (i) Where changes in a and services covered Medicaid State plan, t notice to residents of t reasonably possible. (ii) Where changes are items and services tha facility must inform the 60 days prior to implet (iii) If a resident dies of transferred and does of facility must refund to representative, or esta deposit or charges alm per diem rate, for the of resided or reserved or facility, regardless of a discharge notice requi (iv) The facility must re resident representative the resident within 30 date of discharge from (v) The terms of an act behalf of an individual facility must not conflic these regulations. This REQUIREMENT by: Based on record revie provider failed to provid Advance Beneficiary N Notice of Medicare No	a resident's stay, of services and of charges for those y charges for services not are/ Medicaid or by the the charge are made to items by Medicare and/or by the he facility must provide the change as soon as is e made to charges for other at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any eady paid, less the facility's days the resident actually retained a bed in the any minimum stay or irements. efund to the resident or e any and all refunds due days from the resident's on the facility. Imission contract by or on seeking admission to the ct with the requirements of is not met as evidenced ew and policy review, the ide Skilled Nursing Facility Notice (SNF ABN) and on-Coverage (NOMNC) for	F	Past noncompliance correction required.	e: no plan of		

Facility ID: 0004

TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	CONSTRUCTION		TE SURVEY MPLETED
		435096	B. WING		11/07/2024	
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 582	on review of the correction include: Review of provider's of advanced beneficiary 10/11/24, the provider worker (SW) O had n ABNs or NOMNCs fo Medicare Part A skille *Administrator A inter on 10/16/24. -SW O had reported the hiring on how to compare the shiring on how to compare the provider for review on 11/1 Beneficiary Notification revealed: *Three randomly select the provider for review *Resident 247's Medie ended on 9/23/24, Rest the SNF ABN form CI CMS-10123 by the provider implement deficient practice doe correction included S nurse manager D, DO SNF ABN and NOMN 10/25/24, administrate each resident dischart	ective actions the provider g the incident. Findings documentation regarding notices (ABN) revealed on r identified previous social ot been completing SNF r residents who received to services. viewed (SW) O and SW P he was not trained upon his blete the ABNs by SW P. she had trained SW O upon omplete the ABNs. 6/24 of the provider's SNF on Review Form CMS-20052 ected residents were given to w of SNF ABN. care A skilled services esdient 247 was not given MS-10055 or NOMNC form rovider prior to the end of his ices. CMS-20052 for why the ere not given to resident 247	F 582			

Facility ID: 0004

If continuation sheet Page 3 of 23

		ID HUMAN SERVICES				FORM): 12/09/2024 // APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE	CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			
		435096	B. WING				C 07/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	HOME SIOUX FALLS						
	CURMADY CT	ATEMENT OF DEFICIENCIES		SI	IOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	from these audits will Committee. It was correcord review revealed plan of correction and those involved in SNF issuance. Based on the above in at F582 occurred on 1 the provider's implement the deficient practice of non-compliance is con- non-compliance. Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the maglect, misappropria and exploitation as defined exploitation as defined includes but is not limic corporal punishment, any physical or chemit treat the resident's met §483.12(a) The facility §483.12(a)(1) Not use physical abuse, corpo- involuntary seclusion; This REQUIREMENT by: Based on South Dako (SD DOH) Facility Rep- record review, intervier provider failed to ensure	be reported to QAPI infirmed on 11/5/24 after d the facility developed a education was provided to FABN and NOMNC information, non-compliance 10/11/2024, and based on ented corrective action for confirmed on 11/5/2024, the insidered past Neglect In Abuse, Neglect, and right to be free from abuse, tion of resident property, fined in this subpart. This ited to freedom from involuntary seclusion and cal restraint not required to addical symptoms. If must- e verbal, mental, sexual, or ral punishment, or is not met as evidenced ota Department of Health ported Incident (FRI), w, and policy review the		582	On 10/7/2024 in response to CNA N DON B reviewed the medication administration records of residents and 38 and identified that the narco were noted by RN F as being admir On 10/7/2024 DON B verified that th narcotics were removed from the bl packs for residents 3, 14, and 38 ar signed off by RN F in the facility nar book. On 10/7/2024 DON B checked the p assessment completed by the nurse RN F's shift (10/6/2024 night shift a 10/7/2024 day shift) and verified tha level had not increased and was be properly managed per narcotic med administration as ordered for reside 3,14, and 38.	3,14, nistered he lister nd rcotic pain es after nd at pain lication	

Facility ID: 0004

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE :	. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1		COMPL	
						;
		435096	B. WING		11/0	7/2024
AME OF PR	OVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			19	901 SOUTH HOLLY AVENUE		
SEIHANY	HOME SIOUX FALLS		S	IOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 600	38, 39, and 40) had the and received treatment ordered by one of one during a twelve-hour is a twelve-hour is "On 10/6/24 RN F has a.m. until 11:00 a.m. is locate her during this ""Certified nursing as aide N had to remind morning narcotics for never saw RN F go in give those medication 2. Review of the providocumentation indica camera footage was F: *"RN Fon the unit at 6:00 a.m. Then she:" -"Counted the narcotion of the arcotion of the the arcotion of th	22, 23, 25, 26, 27, 28, 36, heir blood sugar checked nt and medications as e registered nurse (RN) F shift. Findings include: If FRI submitted on 10/9/24 ad left her unit from 9:00 and staff were unable to time." sistant (CNA)/medication RN F multiple times to give three residents, but she or out of those rooms to hs, but they were signed off." ider's investigation ted the 10/6/24 video reviewed and revealed RN 5:27 a.m. Her shift began at a.m. and returned at 9:47 c medication drawer and btic blister packs from that ething with them on the yed the narcotic sign out ng it." dication at 4:56 p.m. to ualized via video camera tion to one resident	F 600	From 10/7/2024 through 10/10/2024 reviewed Bethany security camera for the date of 10/6/2024 from 0600 to 1 shift) and verified suspicion of RN F be under the influence and noted po diversion as well as concerns regard whereabouts throughout the shift an regarding whether RN Fwas complet assigned tasks. This resulted in DOI initiating a more widespread investig beginning 10/8/2024 through 10/11/2 On 10/8/2024 DON B reviewed the r administration records of residents 1 8,9,10,11,12,13,14,20,21,22,23,25,2 38,39,40 and verified that CNA N ha administered all medications within h of practice to these residents on 10/0 On 10/11/2024 DON B completed a for every resident on the unit as of 1 including residents 1,2,3,5,6,7,8,9,10 14,20,21,22,23,25,26,27,28,36,38,33 identify any treatments that should h completed and the possibility of any adverse effects of not receiving their treatments, insulin, or blood sugars no concerns other than and elevated sugar within normal parameters for 28,10,13,36. An elevated blood sugars of normal limits was noted for reside Avel eCare was notified with orders for resident 6 on 10/6/2024. On 10/11/2024 DON B interviewed five verifited that residents 3 and 25 had effects of dressing change and/or wit treatment possibly not being complet 10/6/2024 by RN F. On 10/22/2024 Nurse Manager D in resident 7 who stated that she had r her nebulizer treatment on 10/6/2022 On 10/7/2024 RN F did not report to On 10/8/2024 DON B suspended RI regarding allegation of diversion and	botage for 800 (RN F appearing te sible drug ling RN F d questions ting her N B lation 2024. nedcation ,2, 3, 5,6,7 6,27,28,36, d ner scope 5/2024. chart audit 0/6/2024 0,11,12,13, 9,40 to ave been documented scheduled and found d blood residents ar outside int 6 and received RN E and no adverse ound eted on terviewed ecceived 4. work. N F	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 435096 B. WING 11/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1901 SOUTH HOLLY AVENUE** BETHANY HOME SIOUX FALLS SIOUX FALLS, SD 57105 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) On 10/7/2024 DON B provided a personal in-service and coaching for CNA N on the importance of reporting and advised her that F 600 Continued From page 5 F 600 the concerns that had regarding RN F on 10/6/2024 should have been reported to the -"Gave report at 6:11 p.m. to on-coming nurse." -"Counted the narcotics at 6:20 p.m. with the on-call manager immediately. on-coming nurse." On 10/9/2024 DON B notified the SD DOH regarding RN F leaving the unit, suspicion of drug diversion, and resident neglect by RN F. -"The count was correct." On 10/11/2024 DON B notified the SFPD regarding suspicion of diversion and neglect 3. Review of the provider's 10/11/24 resident by RN F chart audit for the resident's RN F had been responsible for during her 10/6/24 shift revealed: On 10/11/2024 DON B, Administrator A, and Nurse Manager D contacted BHSF Medical Director to inform him of RN F leaving the unit, *Resident 1 should have had a lidocaine 4% suspicion of diversion on 10/6/2024, and the possibility of narcotics and insulins not being administered by RN F on 10/6/2024, and the possibility of blood sugars not being checked, patch (for pain) applied to both of her shoulders. *Resident 2 should have had an Aspercreme 4% patch (for pain) applied to her lower back and and the possibility of treatments not being completed by RN F on 10/6/2024. Advised by the Medical Director to notify the physician of every resident identified. Voltaren gel (for pain) to her hands at 8:00 a.m. and 12:00 p.m. *Resident 3 should have had the dressing On 10/11/24 Nurse Manager D notified the physician for residents 1,2,3,5,6,7,8,9,10.11,12 13,14,20,21,22,23,25,26,27,28,36,38,39,40 of the possibility of narcotics and insulins not being administered by RN F on106/24 and the possibility of blood sugars not being checked ond the possibility of blood sugars not being checked and the possibility of blood sugars not being checked and the possibility of blood sugars not being checked blood sugars not be not blood sugars changed to her right leg incision and Oxycodone 2.5 milligrams (mg) (for pain) given at 8:00 a.m. and 12:00 p.m. *Resident 5 should have had her blood sugar and the possibility of treatments not being completed by RN F on 10/6/24. checked at 7:00 a.m. RN F had documented the On 10/11/2024 DON B and Administrator A resident's blood sugar result 103 mg/deciliter contacted the Avera LTC Pharmacy to report the suspected drug diversion and to review the (dL). "Drug Diversion" policy and found it to be correct. A complete review of the policy was *Resident 6 should have had applied Triad paste (for wound healing) applied to her bottom, completed to assure that all appropriate actions had beeen taken. received Tresiba insulin 35 units subcutaneously. On 10/11/2024 DON B accepted RN F and had her blood sugar checked three times and resignation. had insulin administered to her based on her On 10/14/2024 DON B initiated that she or her sliding scale subcutaneously as needed. RN F designee will complete an ongoing narcotic count audit on Promise Lane at random times had documented the resident's blood sugar during the day to ensure that the narcotic count results as: is accurate, all signatures present, and no concerns identified twice a day x 1 week, then daily x 1 week, the 3 x a week x 1 month, then once a week thereafter. The DON or her -At 8:00 a.m. 201 mg/dL and had administered six units of sliding scale insulin. designee will report findings to the the quarterly QAPI committee for as long as the committee -At 11:00 a.m. 201 mg/dL and had administered six units of sliding scale insulin. deems necessary -At 5:00 p.m. 203 mg/dL and had administered six units of sliding scale insulin. --At 9:00 p.m. 600 mg/dL. Avel e-health had been notified and orders received for extra insulin. *Resident 7 should have had been given a

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 0004

If continuation sheet Page 6 of 23

	FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMP	LETED
						C
		435096	B. WING	^		07/2024
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
BETHANY	HOME SIOUX FALLS			1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
					DDEATION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
	breathing problems) at budesonide 0.5 mg m problems) at 8:30 a.m *Resident 8 should ha patch (for pain) applie morning. *Resident 9 should ha her lips. *Resident 10 should h unit dose nebulizer (fr 7:00 a.m., 11:00 a.m. units subcutaneously subcutaneously at 6:0 -RN F had documents sugar results as: At 7:00 a.m. 103 mg At 11:00 a.m. 103 mg *Resident 11 should h suppository (for consi *Resident 12 should wound healing) applie *Resident 13 should h units subcutaneously blood sugar checks th (for pain) ointment to 4% patch (for pain) to RN F documented the result and sliding sca administered as: -At 7:00 a.m. 243 mg units of insulin subcu	ms (mcg) nebulizer (for at 8:00 a.m. and a ebulizer (for breathing h. and 3:30 p.m. ave had a Lidocaine 4% ed to his back in the ave had Vaseline applied to have been given a Duoneb or breathing problems) at , and 5:00 p.m., Humulin 14 at 8:00 a.m. and six units 00 p.m. ed the resident's blood g/dL. ng/dL. g/dL. have been given a Biscodyl tipation). have had Triad paste (for ed to her bottom. have been Lantus insulin 48 ta 7:00 a.m. and 5:00 p.m., hree times, Aspercreme 4% her hands, and Lidocaine to both the resident's knees. e resident's blood sugar le Novolog insulin /dL and administered four taneously. g/dL and administered four	F 60		filed a complaint ng regarding RN F on of diversion and F. ugh 11/5/2024 DOI idents 1,2,3,5,6,7, 2,23,25,26,27,28, members tus of the possibilit ssibly not being 0/6/2024 and/or ars not being lity of treatments F on 10/6/2024 Administrator A and neglect cotic count audit to the Staff Develop. Identify the need uspicion of all CNAs ocluding the need uspicion of a staff fluence and/or for an extended I her designees nurses on s and consequence strator, DON, and oblaboration with the e "BHSF Abuse, fliaboration with the e "BHSF Abuse, for the care team ootential for resider trator, DON, and ID edical Director glect". "Identifying	y es e

Facility ID: 0004

If continuation sheet Page 7 of 23

	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	0. 0938-03 SURVEY PLETED
		435096	B. WING			C 07/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			11	901 SOUTH HOLLY AVENUE		
BETHAN	HOME SIOUX FALLS		s	IOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 600	and had a dressing an *Resident 21 should h applied to her coccyx *Resident 22 should h cream (a skin protects *Resident 23 should h at 7:00 a.m. -RN F had documents 199 mg/dL. *Resident 25 should h changed to his first and 2% (antifungal) crear Ketoconazole 2% sha *Resident 26 should h wound healing) applie unit dose nebulizer (for a Pulmicort 0.5 mg ne problems) at 10:00 a. *Resident 27 should h units subcutaneously, 7:00 a.m. and 5:00 p. the following blood su -At 7:00 a.m. 199 mg/ -At 5:00 p.m. 103 mg/ *Resident 28 should h insulin subcutaneousl buttock, and a blood s *Resident 36 should h checked three times w insulin administered a checks. RN F had doo sugars results as:	rally at 8:00 a.m. have had his scalp cleansed pplied. have had barrier cream have had Calmoseptine ant) applied to her buttock. have had her blood checked ed a blood sugar result of have had a dressing Mupirocin cream (antibiotic) d second toes, Ketoconazole m applied to his face, and ampoo to his scalp. have had Triad paste (for ed to her buttock, a Duoneb or breathing problems), and ebulizer (for breathing m. and 6:00 p.m. have had Lantus insulin 42 , her blood sugar checked at m. RN F had documented togar results as: rdL. rdL. have had Levemir 25 units of sugar check. RN F had sugar result of 102 mg/dL. have her blood sugar with sliding scale Humalog as needed with blood sugar cumented resident's blood	F 600	to clearly define what constitutes and negligence. On 11/26/2024 the Administrato and Nurse Managers created th Resident and Employee Accoun Procedure" to establish a proces identifies the person responsible regular rounding (documented of daily door sheet) on all shifts to presence and well-being of both residents. The procedure also re completion of a rounding checkl Beginning 12/2/2024 the DON of designee will provide education on the "BHSF Abuse, Neglect, E and Misappropriation of Resider "BHSF Types of Abuse", "BHSF Sexual Abuse and Capacity to O and the "BHSF Resident and Em Accountability Procedure". Educ be completed by 12/6/2024. Beginning 12/6/2024 the DON of designee will audit the door sheet to ensure that the person respor regular rounding is identified. Th her designee will report findings quarterly QAPI committee for as the committee deems necessary Beginning 12/6/2024 the DON of designee will audit the "Residen Rounding Checklist" daily x 4 we then weekly thereafter to ensure completionand to address any a concern. The DON or her design report findings to the quarterly G committee for as long as the cor deems necessary.	r, DON, e "BHSF tability ss that e for in the assure the staff and equires the ist. r her for all staff cxploitation, it Property" Identifying Consent", nployee ation will r her et every da isible for to the long as v. r her t and Staff eeks and its reas of nee will API	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING С B. WING 435096 11/07/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1901 SOUTH HOLLY AVENUE BETHANY HOME SIOUX FALLS SIOUX FALLS, SD 57105 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 600 Continued From page 8 F 600 insulin administered. -At 5:00 p.m. 133 mg/dL with no sliding scale insulin administered. *Resident 38 should have had Biofreeze (for pain) applied to both of his knees, Lidocaine 4% gel (for pain) applied to the lower back, and Oxycodone 5 mg orally at 8:00 a.m. and 12:00 p.m. *Resident 39 should have had Benadryl cream (for pain and itching) applied to both arms and leas. *Resident 40 should have had a blood sugar checked. RN F had documented a result of 103 mg/dL. 4. Interview on 11/7/24 at 2:40 p.m. with director of nursing (DON) B regarding the investigation regarding RN F's care of residents on 10/6/24 revealed: *DON B had reviewed the video footage for 10/6/24 involving RN F. *DON B had been able to verify RN F had not entered the above listed residents' rooms during her shift to provide the documented cares and medications. *She had interviewed other staff that had provided care for residents on the unit RN F had been assigned to on 10/6/24. -Those interviews had verified RN F had not been seen entering the above resident's rooms. *Education would be provided to all CNA's on 11/14/24 regarding the investigation results from this incident. *Education would be provided to all nurses on 11/21/24 regarding the investigation results from this incident. Review of the provider's November 2023 Prevention of Resident Abuse, Neglect, and

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 0004

If continuation sheet Page 9 of 23

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STREE, ZP CODE BETHANY HOME SIOUX FALLS 101 SUMMARY STREEMENT OF DEFICIENCIES (CACH DEFICIENCIES PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDENT PARA OF CORRECTION (RCACH DEFICIENCIES PULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIX REGULATORY OR LSC IDENTIFY INFORMATION) ID PREVIX REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREVIX REGULATORY OR LSC IDENTIFY INFORMATION) ID PREVIX REGULATORY OR LSC IDENTIFY INFORMATION) ID PREVIX REGULATORY OR LSC IDENTIFY INFORMATION REGULATORY OR LSC IDENTIFY INFORMATION) <td></td> <td></td> <td>435096</td> <td>B. WING</td> <td></td> <td></td> <td></td> <td></td> <td></td>			435096	B. WING					
BETHARY HOME SIOUX FALLS SUXX FALLS, SD 57165 OW10 PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE FROZEDED BY FULL REGULATIONY OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION PREFIX REGULATIONY OR LSC IDENTIFYING INFORMATION) PROVIDENTIFYING CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRATE DEFICIENCY) CONTINUENT DEFICIENCY) CONTINUENT DEFICIENCY) F 600 Continued From page 9 Misappropriation of Resident Policy revealed: ""Each resident from abuse, neglect, and misappropriation of property by Bethany employees, oftner residents, consultants, volunteers, employees of other agencies serving the resident, frendly members and legal guardians, friends or other individuals." "Bethany Will not tolerate the abuse, neglect, or misappropriation of Defarte the abuse, neglect, or misappropriation of Bethany." F 623 F 2623 S483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the residents representative(s) of the transfer or discharge and the reasons for the movie in writing and in a language and manner they understand. The facility must send a copy of the office of the State Long-Franc Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	NAME OF PF	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			///EVE4
MAID PRETX TXS SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECT NE ACTION SHOULD BE RESULTION OF ALL SCIENTIFYING INFORMATION) ID PRETX TXS PROVIDER'S PLAN OF CORRECTION (EACH CORRECT NE ACTION SHOULD BE CORDSS REFERENCIES ACTION SHOULD BE DEFICIENCY) Operation (EACH CORRECT NE ACTION SHOULD BE DEFICIENCY) F 600 Continued From page 9 Misappropriation of Resident Policy revealed: ""Each resident fixing at Bethary has the right to be free from abuse, neglect, and misappropriation of property by Bethany employees, other residents, consultants, volunters, employees of other approximations; F 600 F 623 Notice sequimements Before Transfer: Bethary will not tolerate the abuse, neglect, or misappropriation of property by Bethany employees, other residents, volunters, employees of other apprices provide available for survey review during the survey. F 623 F 623 S483.15(c)(3) Notice before transfer: Before a facility transfer or discharges a resident, the facility must- representative of the romiser or discharge and manner they understand. The facility must send a copy of the transfer or discharge in the realident section to a representative of the Office of the State Long-Term Care Ombudsman. F 623 (i) Notice the reasons for the transfer or discharge in the realident section to a coordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in F	BETHANY	HOME SIOUX FALLS							
FigErix Tas EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX Tas CECAH CORRECTIVE ACTION SHOLLD BE URDER HEAPROPERTY CONVECTIVE ACTION SHOLLD BE URDER HEAPROPERTY F 600 Heapproprisition of property by Bethany employees, a consultant, or others working under the direction of Bethany." F 623 F 623 F 623 F F523 SHOE Requirements Before Transfer/Discharge a resident, the facility transfers or discharges a resident, the facility transfers or discharges a resident, the facility transfers or discharge and the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(SUMMARY ST					RECTION		(VE)
Misappropriation of Resident Policy revealed: **Each resident living at Bethany has the right to be free from abuse, neglect, and misappropriation of their property. Bethany will enforce policies and procedures that protect each resident from abuse, neglect, and misappropriation of property by Bethany employees, other residents, consultants, volunteers, employees of other agencies serving the resident, family members and legal guardians, firedos or other individuals." ***Bethany will not tolerate the abuse, neglect, or misappropriation of property of any resident by any employee, a consultant, or others working under the direction of Bethany." The video surveillance for 10/6/24 was not made available for survey review during the survey. F 623 Se=D CFR(s): 483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasident ror discharge in the resident record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE		COMPLET
Misappropriation of Resident Policy revealed: ""Each resident living at Bethany has the right to be free from abuse, neglect, and misappropriation of their property. Bethany will enforce policies and procedures that protect each resident from abuse, neglect, and misappropriation of property by Bethany employees, other residents, consultants, volunteers, employees of other agencies serving the resident, family members and legal guardians, firendo or other individuals." guardians, firendo so or ther individuals." ""Bethany will not tolerate the abuse, neglect, or misappropriation of property of any resident by any employee, a consultant, or others working under the direction of Bethany." The video surveillance for 10/6/24 was not made available for survey review during the survey. F 623 Notice Requirements Before Transfer/Discharge F 623 SS=D CFR(s): 483 15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the orige and an the reasons for the notice to a representative of the Office of the State Long-Term Care Ombudsman. (i) Record the resident resident roor discharge or discharge in the resident provide the succe or in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in	F 600	Continued From page	9	Fé	500				
discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in		*"Each resident living be free from abuse, n misappropriation of th enforce policies and p resident from abuse, misappropriation of p employees, other res volunteers, employee the resident, family m guardians, friends or *"Bethany will not tole misappropriation of p any employee, a consulter under the direction of The video surveillanc available for survey re Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility transform (i) Notify the resident representative(s) of th the reasons for the m language and manne facility must send a cor representative of the Long-Term Care Omb	at Bethany has the right to aeglect, and heir property. Bethany will procedures that protect each neglect, and roperty by Bethany idents, consultants, as of other agencies serving embers and legal other individuals." arate the abuse, neglect, or roperty of any resident by sultant, or others working Bethany." e for 10/6/24 was not made eview during the survey. Before Transfer/Discharge -(6)(8) before transfer. fers or discharges a hust- and the resident's he transfer or discharge and ove in writing and in a r they understand. The poy of the notice to a Office of the State budsman.	F	523				
		accordance with para and (iii) Include in the noti	graph (c)(2) of this section; ce the items described in						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 435096 11/07/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1901 SOUTH HOLLY AVENUE BETHANY HOME SIOUX FALLS SIOUX FALLS, SD 57105 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) ID. (X4) ID COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 623 Continued From page 10 F 623 §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section: (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and

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Facility ID: 0004

If continuation sheet Page 11 of 23

	MENT OF HEALTH A S FOR MEDICARE &	MEDICAID SERVICES				RM APPROV IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY
		435096	B. WING			C 1/07/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST		1/0//2024
				1901 SOUTH HOLLY AVENU	JE	
BEIHANT	HOME SIOUX FALLS			SIOUX FALLS, SD 5710	5	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S	PLAN OF CORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFEREN	TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	COMPLETI
F 623	Continued From pag	je 11	F 6	23		
	telephone number o	f the Office of the State				
	Long-Term Care Om	ibudsman;				
		ty residents with intellectual				
	and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for					
		dvocacy of individuals with				
	-	-				
	developmental disabilities established under Part C of the Developmental Disabilities Assistance					
	and Bill of Rights Act	t of 2000 (Pub. L. 106-402,				
	codified at 42 U.S.C.	• • •				
		ity residents with a mental				
		isabilities, the mailing and elephone number of the				
		for the protection and				
		als with a mental disorder				
		e Protection and Advocacy				
	for Mentally III Individ	duals Act.				
	§483.15(c)(6) Chang					
		he notice changes prior to				
1	-	or discharge, the facility				
		pients of the notice as soon				
	becomes available.	the updated information				
	§483.15(c)(8) Notice in advance of facility closure					
	In the case of facility	closure, the individual who is				
		he facility must provide				
		ior to the impending closure				
		Agency, the Office of the re Ombudsman, residents of				
	-	esident representatives, as				
well as the plan for the transfer and a relocation of the residents, as require						
		•				
	483.70(k).					
		T is not met as evidenced				
	by: Based on interview:	and record review, the		Past noncomplianc	o: no plan of	
	Dased on Interview a			East noncompliance	e. no dian or	11

		MEDICAID SERVICES				OMB NO	SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
			A. BUILDIN	vo _	с		
		435096	B. WING			1	07/2024
AME OF PI	ROVIDER OR SUPPLIER		-	ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
				19	01 SOUTH HOLLY AVENUE		
SETHANT	HOME SIOUX FALLS			SI	IOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 000		10					
F 623			Fe	323			
		vide a written notice of			correction required.		
	transfer or discharge	ransfer or discharge, for two					
		ents reviewed (31 and 45).					
		dered past non-compliance					
		ne corrective actions the					
		d after discovering the lack					
	of documentation.						
	Findings include:						
	1. Interview and reco	rd review on 11/5/24 at 11:51					
	a.m. with administrat						
	*Administrator A prov	rided the survey team with a					
		ation timeline and their plan					
	of correction (POC) of						
	* They discovered a list variety of required no	ack of documentation for a					
	*The management te						
		mine the extent of the issue.					
		worker was responsible for					
	providing required no	otices to residents or their					
	•	t former employee was not					
		d written notices, including					
	transfer or discharge	s were educated on the					
	required written notic						
		conducted, and corrections					
	were completed.						
	2. Review of residen	t 31's electronic medical					
	record (EMR) reveal					36	
		to the local emergency					
		24, and again on 9/1/24.					
		mentation found about a discharge, or that the					
	ombudsman was not	-					
	2 Doutour of residen	t 45's alastronia madisal					
	I 3. Review of residen	t 45's electronic medical					1

CENTERS FOR MEDICARE & MEDICARD SERVICES OMB NO. 0938-031 WITTERWOY FOR DECINCES MID PROVEERSUPPLIER V11 PROVEENSUPPLIER V2 MULTIPLE CONSTRUCTION V2 M							FORM	D: 12/09/2024
VMME OF PROVIDER OR SUPPLIER 435996 B. WING Interface 11107/2024 BETHANY HOME SIOUX FALLS STREET ADDRESS, CITY, STATE, ZP CODE 1901 SOUTH HOLLY AVENUE 5000X FALLS, SD 57105 00000 00000	STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	SURVEY
1911 SOUTH HOLLY AVENUE SOUX FALLS, 50 97105 CMM ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCES (EXPLOREMENT MUST EF RECEDED BY FULL REGULTORY OR LSC IDENTERING INFORMATION) PRETX PRETX PRETX TAG REGULTORY OR LSC IDENTERING INFORMATION) PRETX PRETX CROSS-REFERENCES CROSS-REFERENCES (EROSS-REFERENCES) OWNER (EROS)-REFERENCES DEFICIENCY) OWNER CROSS-REFERENCES DEFICIENCY) F 623 Continued From page 13 "She transferred to the local emergency department on 8/12/24. "There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified. F 623 4. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about the required notices revealed that she was not sure if the notices were completed correctly due to an issue with the previous social worker. F 623 5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, aducation was provided to the nurse managers about required notices, interviews revealed staff understood the education provided regarding those topics, and a review of recently transferred or discharged residents revealed no the provider's implemented orrective action for the deficient practice confirmed on 11/5/24, the non-compliance is considered past non-compliance is considered past non-compliance. F 625			435096	B. WING_			1	
BETHANY HOME SIOUX FALLS SIOUX FALLS, SD 57105 (%4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OERCIDENCY WIST BE PRECEDED DO FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PREFIX (EACH OERCIDENCY WIST BE PRECEDED DO FULL (EACH OERCIDENC MUST BE PRECEDED TO THE APPROPRIATE DEFICIENCY) 000 (EACH OERCIDENC THE APPROPRIATE DEFICIENCY) 000 (EACH OERCIDENC ATTENDE APPROPRIATE DEFICIENCY) 000 (EACH OERCIDENC ATTENDED TO THE APPROPRIATE DEFICIENCY) 000 (EACH OERCIDENCE ATTENDED TO THE APPROPRIATE DEFICIENCY) 000 (EACH OERCIDENCE (EACH OERCIDENCE ATTENDED TO THE APPROPRIATE OERCIDENCE ATTENDED TO THE APPROPRIATE DEFICIENCY 000 (EACH OERCIDENCE (EACH OERC	NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
(M4) ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH DERICENCY STATEMENT OF DEFICIENCIES (EACH DERICENCE TO THE APPROPRIATE DEFICIENCY) (%) F 623 Continued From page 13 *She transferred to the local emergency department on 8/12/24. *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified. F 623 4. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about the required notices revealed that she was not sure if the notices were completed correctly due to an issue with the previous social worker. 5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse managers about required notices, interviews revealed staff understood the education provided regarding those topics, and a review of recently transferred or discharged residents revealed notices were provided as required. Based on the above information, non-compliance at F623 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance. F 625	BETHANY	HOME SIOUX FALLS						
Préérix Tx6 (EACH DERIGENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX Tx6 CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCE TO THE APPROPRIATE DERICENCY) COMMETTING DERICENCY) F 623 Continued From page 13 *She transferred to the local emergency department on 8/12/24. F 623 *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified. F 623 4. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about the required notices revealed that she was not sure if the notices were completed correctly due to an issue with the previous social worker. F 623 5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse managers about required notices, interviews revealed staff funderstood the deducation provided regarding those topics, and a review of recently transferred or discharged residents revealed notices were provided as required. F 625 Based on the above information, non-compliance at F623 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance. F 625					S	IOUX FALLS, SD 57105		
*She transferred to the local emergency department on 8/12/24. *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified. 4. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about the required notices revealed that she was not sure if the notices were completed correctly due to an issue with the previous social worker. 5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse managers about required notices, interviews revealed staff understood the education provided notices were provided as required. Based on the above information, non-compliance at F623 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance is considered past non-compliance. F 625 Notice of Bed Hold Policy Before/Upon Trnsfr F 625	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION
§483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625	*She transferred to the department on 8/12/2 *There was no docum notice of transfer or di ombudsman was not 4. Interview on 11/7/2 manager D about the that she was not sure completed correctly di previous social worke 5. The provider's impli- the deficient practice of confirmed on 11/5/24 the facility had follower process, education wa managers about requi revealed staff underst regarding those topics transferred or dischare notices were provided Based on the above in at F623 was discovered on the provider's impli- for the deficient practi- the non-compliance is non-compliance. Notice of Bed Hold Pot CFR(s): 483.15(d)(1) Notice for \$483.15(d)(1) Notice of the system	e local emergency 4. entation found about a ischarge, or that the fied. 4 at 8:40 a.m. with nurse required notices revealed if the notices were ue to an issue with the r. emented actions to ensure does not reoccur was after record review revealed ad their quality assurance as provided to the nurse ired notices, interviews ood the education provided a, and a review of recently ged residents revealed I as required. nformation, non-compliance ed on 10/11/24, and based emented corrective action ce confirmed on 11/5/24, a considered past blicy Before/Upon Trnsfr 2) ped-hold policy and return- pefore transfer. Before a rs a resident to a hospital or herapeutic leave, the					

Facility ID: 0004

If continuation sheet Page 14 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С 435096 B. WING 11/07/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE BETHANY HOME SIOUX FALLS SIOUX FALLS, SD 57105 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 625 Continued From page 14 F 625 the resident or resident representative that specifies-(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility: (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483,15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced bv: Past noncompliance: no plan of Based on interview and record review, the correction required. provider failed to provide a written bed-hold notice to the resident or their representative when transferred to the emergency department for one of two sampled residents reviewed (45). This citation is considered past non-compliance based on review of the corrective actions the provider implemented after discovering the lack of documentation. Findings include: 1. Interview and record review on 11/5/24 at 11:51 a.m. with administrator A revealed: *Administrator A provided the survey team with a copy of their investigation timeline and plan of

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 0004

If continuation sheet Page 15 of 23

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/09/2024 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		435096	B. WING_			1	C /07/2024
	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	correction (POC) doci *They discovered a la variety of required not *The management tea investigation to detern *The previous social w providing required not former employee was written notices, includ *The nurse managers required written notice *Chart reviews were of were completed. 2. Review of resident record revealed: *She admitted to the f *She transferred to the department on 8/12/24 *The social worker sp representative about to 8/12/24. Written notice *The resident's repress hold the bed and gath belongings from the fa 3. Interview on 11/7/27 manager D about bed *The written bed hold have been done" due former social worker. *The resident had not facility as she was adr 4. The provider's implet the deficient practice of confirmed on 11/5/24.	umentation. lick of documentation for a tices on 10/11/24. am completed an nine the extent of the issue. worker was responsible for tices to residents. That not providing the required ing bed hold notices. were educated on the es on 10/16/24. conducted, and corrections 45's electronic medical facility on 7/23/24. e local emergency 4. oke with the resident's the bed hold policy on e was not documented. sentative verbally declined to lered resident 45's acility on 8/12/24. 4 at 8:40 a.m. with nurse hold notices revealed: notices were "unlikely to to a situation with the requested to return to the mitted to hospice services.	F	625			

Facility ID: 0004

If continuation sheet Page 16 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	10			OWB NC	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.1.1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435000	B. WING				0
		435096	B. WING	3		11/	07/2024
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHANN	HOME SIOUX FALLS			1	901 SOUTH HOLLY AVENUE		
				8	SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 625 F 657 SS=D	managers about requirevealed staff undersi- regarding those topics discharged residents provided as required. Based on the above in at F625 was discover on the provider's impl for the deficient practi- the non-compliance is non-compliance. Care Plan Timing and CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A comp- be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int- includes but is not lim (A) The attending phy	ired notices, interviews and a review of recently revealed notices were information, non-compliance ed on 10/11/24, and based emented corrective action ce confirmed on 11/5/24, considered past Revision i)-(iii) ensive Care Plans brehensive care plan must days after completion of esessment. erdisciplinary team, that ited to		625	On 11/25/2024 the DON added the of dementia to resident 11 care plan on 11/27/2024 during the review of 11 comprehensive care plan it was that the Seroquel was not on the me review as the medication was disco on 11/12/2024. The focus for Seroq not added to the care plan due to it discontinued. On 11/25/2024 the DON added the of Apixaban to resident 25 care plan	n. resident noted edication ntinued uel was being focus	
	resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and the resident and the resident reprised and their resident reprised to the resident's care plan. (F) Other appropriate	responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined development of the staff or professionals in ned by the resident's needs			to blood clot prevention. On 11/25/2024 the DON reviewed th of Care" policy and found it to be co On 11/26/2024 the DON will provide education to all nurse managers, the worker, and the MDS Coordinator of "Plan of Care" policy. Beginning 11/26/2024 the DON or h designee along with the IDT will rev. current comprehensive care plans e that the diagnosis list and medicatio are reconciled in the care plan.	rrect. e social n the er iew all ensuring	

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Facility ID: 0004

DEPARTMENT OF HEALTH AND HUMAN SERVICES

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						0
		435096	B. WING		11/	07/2024
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	Y HOME SIOUX FALLS			1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 657	 (iii)Reviewed and reviteam after each assessments. This REQUIREMENT by: Based on record revitreview, the provider fafor two of two sample been updated to reflere Findings include: 1. Review of resident record (EMR) reveale *On 8/6/24 she had redementia and other delsewhere. *On 8/15/24 an order Seroquel 100 milligratiday related to Major E 2. Review of resident *On 8/20/24 the care indicated the use of smedications related to depression. No focus diagnosis of dementia 3. Review of resident *On 8/23/24 an order Apixaban 2.5 mg (block fibrillation by mouth two clot prevention. 4. Review of resident *On 10/29/24 the care did not indicate that the second second	 ised by the interdisciplinary ssment, including both the juarterly review is not met as evidenced iew, interview, and policy ailed to ensure the care plan d residents (11and 25) had ct their current condition. 11's electronic medical d: eceived a diagnosis for iseases classified had been received to start m (mg) by mouth one time a Depressive Disorder. 11's care plan revealed: plan had been updated and cheduled psychotropic op pain management and area on resident's a was noted in the care plan. 25' s EMR revealed: had been received to start 	F 657	Beginning 12/6/2024 the DON designee will meet monthly to comprehensive care plans of in their quarterly review windo all diagnosis and the medicati items are in the comprehensiv Beginning 12/6/2024 the DON designee will audit 3 residents ensure all diagnosis and the m review items are on the comp plan. The DON or her designee findings to the quarterly QAPI for as long as the committee of necessary.	review the the residents w to ensure on review /e care plan. I or her s weekly to nedication rehensive care se will report committee	

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	F DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE CO	NSTRUCTION		10. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
						С
		435096	B. WING		1	1/07/2024
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	HOME SIOUX FALLS			SOUTH HOLLY AVENUE		
			SIOU	JX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 18	F 657			
	of nursing B, nurse m A revealed: *The manager of eac updating the resident * Any staff member w also responsible for u * During the interview and nurse manager D	who processes an order, is updating the care plan. y, administrator A, DON B, D agreed that residents 11 nad not been updated to				
	policy revealed: * "Care Plans will be ongoing basis. This in reviewed and update changes as well as q could include recent admissions to hospic other traits that reflect emotional status." * "The nurse manage process such as daily review of all new orde sheets, daily review of daily review at IDT he care plan current. Th the plan of care to cre- flowsheets." Menus Meet Resider CFR(s): 483.60(c)(1)	e, new acute diagnosis, and at a decline is physical and er will complete a daily y walking event rounds, daily ers, daily review of 24-hour of progress notes and/or uddle in order to keep the e nurse manager will utilize eate CNA's daily/weekly care at Nds/Prep in Adv/Followed	F 803			
	§483.60(c)(1) Meet ti	he nutritional needs of				

TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	
ND PLAN U	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		435096	B. WING			(
NAME OF P	ROVIDER OR SUPPLIER		ī	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	07/2024
					001 SOUTH HOLLY AVENUE		
BETHAN	HOME SIOUX FALLS			SI	IOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 803	guidelines.; §483.60(c)(2) Be prep §483.60(c)(3) Be follo §483.60(c)(4) Reflect reasonable efforts, th ethnic needs of the re- input received from re- groups; §483.60(c)(5) Be upd §483.60(c)(6) Be revi- dietitian or other clinic professional for nutrit §483.60(c)(7) Nothing construed to limit the personal dietary choid This REQUIREMENT by: Based on menu revia interview, the provide portions were served one of one observed to affect all residents the facility. Findings include: 1. Review of the prov 11/7/24 revealed the facility	ace with established national pared in advance; owed; c, based on a facility's e religious, cultural and esident population, as well as esidents and resident lated periodically; ewed by the facility's cally qualified nutrition ional adequacy; and g in this paragraph should be resident's right to make ces. is not met as evidenced ew, observation, and r failed to ensure adequate according to the menu for meal. This had the potential receiving the main menu in ider's menu for lunch on following main menu items: dip x2," which was eight	F		On 11/21/2024 the Dietary Manage Dietician, and Administrator in colla with the Medical Director reviewed "Portion Control Policy" and revised include the need to ensure that the appropriate serving size is what is so out unless the resident has made a preference for a different portion siz On 11/21/2024 the Dietician provide personal in-service education with r demonstration on the "Portion Cont Policy" to Dietary Manager G. On 11/22/2024 the Dietary Manage the Dietician reviewed the weekly m extentions and found it to be correct On 11/22/2024 Dietary Manager G that the kitchen was stocked with th portion sized serving utensils to cor with the weekly menu with extensio On 11/25/2024 Dietary Manager G a corrective action and personal in- education with return demonstration L on the "Portion Control Policy". Beginning 11/22/2024 Dietary Manager G a dill provide education with return demonstration to all cooks on the "F Control Policy" Beginning 12/2/2024 Dietary Manager on a daily basis x 4 weeks and ther thereafter. Dietary Manager G or he designee will report findings to the c QAPI committee for as long as the committee deems necessary.	boration the l it to served choice/ ze. ed a eturn rol r G and henu with t. confirme le correct relate ns. provided service n to cook ager G Portion ger G or vation vice time weekly er	d s

Facility ID: 0004

If continuation sheet Page 20 of 23

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING С B. WING 435096 11/07/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1901 SOUTH HOLLY AVENUE BETHANY HOME SIOUX FALLS SIOUX FALLS, SD 57105 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ١D (X4) ID COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 803 Continued From page 20 F 803 2. Observation on 11/7/24 at 11:11 a.m. in the kitchen during lunch service revealed: *Cook L was plating the residents' lunch meal food items. *She served a three oz. scoop of the beef & broccoli. -The printed menu indicated the serving size for the regular diet as #8 dip x 2. *Cook L served a heaping two oz. spoodle of diced carrots. -The printed menu indicated the serving size as 4 oz. *Observation of the utensil drawer confirmed that a 4 oz. spoodle and a 4 oz. serving spoon were available. 3. Interview on 11/7/24 at 1:29 p.m. with cook L revealed she: *Was aware of the serving sizes on the printed menu. *Chose not to use the correct serving sizes; she did not provide a reason. 4. Interview on 11/7/24 at 1:34 p.m. with dietary manager G about the above observations revealed she: *Was not aware that dietary staff served the wrong portion sizes for lunch that day. *Was aware of the need to meet the dietary requirements of the residents by following the approved menu, including portion sizes. Food Procurement, Store/Prepare/Serve-Sanitary F 812 F 812 SS=F CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -§483.60(i)(1) - Procure food from sources If continuation sheet Page 21 of 23 Event ID: OGA511 Facility ID: 0004 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				/I APPROVI). 0938-03
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		435096	B. WING			C 07/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		0772024
BETHAN	HOME SIOUX FALLS			SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 812	state or local authoriti (i) This may include for from local producers, and local laws or regu- (ii) This provision doe facilities from using pri- gardens, subject to co- safe growing and food (iii) This provision doe from consuming foods §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observatio review, the facility fail one of one steamer a oven in the kitchen. Findings include: 1. Observation during 11/5/24 from 11:43 a.t *The interior of the Vu was heavily coated in particles. *The interior of the Cl steamer had an excess and scum, and there of bottom of the basin si 2. Interview on 11/7/2 about cleaning the lar revealed: *She claimed that she oven every day, and c	ed satisfactory by federal, ies. bod items obtained directly subject to applicable State ulations. is not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. is not preclude residents is not procured by the facility. prepare, distribute and ince with professional	F 812	On 11/21/2024 Dietary Manager the Vulcan brand convention over On 11/21/2024 Dietary Manager determined the need to remove to Cleveland brand SteamChef stea service due to its age. Dietary M determined not to replace the stea to the infrequency of its use in for preparation. On 11/21/2024 Dietary Manager collaboration with the Dietician a Administrator reviewed the manu- instructions regarding cleaning the brand convection oven and found be correct. On 11/21/2024 Dietary Manager Medical Director, and Administrathe "Oven Cleaning Procedure" I the manufacturer's instructions a states the need to ensure that al preparation equipment is mainta clean and sanitary manner for al On 11/21/2024 the Dietician prov Dietary Manager G with a persor in-service with return demonstrat "Oven Cleaning Procedure" and that it is all food preparation emp responsibility to ensre that all kitte equipment and appliances are w maintained, clean, and sanitary for 0n 11/21/2024 Dietary Manager a daily schedule for the Vulcan c oven which also includes an eve deep cleaning requirement. On 11/22/2024 Dietary Manager in spected all kitchen equipment a appliances and found them to be in good working order.	en. G G amer from anager G eamer due od G in nd the ufacturer's ne Vulcan d them to G, Dietician tor created based on ind that I food ined in a I users. Vided hal tion on the stressed bloyee's chen vell- or use. G created onvection ry 2 week G and	

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Facility ID: 0004

TATEMENT	OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL	
		435096	B. WING		C 11/07/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 812	 about a month. *She did not know the steamer. 3. Interview on 11/7/2 manager G about the revealed: *There was a cleaning equipment. *She performed month cleanliness. *She was unaware the were that dirty. *She did not know the steamer. 4. Review of the provide cleanliness audits revealed: *There was a line item section that read "Over in good repair." There was a checkmittem on the above-list 5. Review of the managuidelines for the Cleat "When done daily this buildup of minerals are" "When done daily this buildup of calcium and over from the boiling of buildup in the steame 	e proper steps to clean the 24 at 1:34 p.m. with dietary oven and steamer g schedule for the kitchen thly audits for kitchen at the oven and steamer e proper steps to clean the ider's monthly kitchen realed: upleted on 8/26/24, 9/30/24, n under the "Maintenance" ens and Steamer clean and ark "Yes" next to that line ed audit sheets. ufacturer's cleaning veland SteamChef revealed escaling daily to prevent the	F 812	On 11/22/2024 Dietary Manage the cleaning schedule for all oth equipment and appliances and the be correct On 11/25/2024 Dietary Manage a personal in-service with return demonstration on the "Oven Cle Procedure" to cook L. On 11/25/2024 Dietary Manage cook L with a personal in-service the daily cleaning schedule and deep cleaning requirment. Beginning 11/22/2024 Dietary M will provide education to all cool "Oven Cleaning Procedure" with demonstration. Beginning 11/22/2024 Dietary M will provide education to all cool "Uven Cleaning Procedure" with demonstration. Beginning 12/2/2024 Dietary M will provide education to all cool Vulcan oven cleaning daily sche every two week deep cleaning re Beginning 12/2/2024 Dietary Ma her designee will audit the Vulca oven daily cleaning and two week cleaning schedule including and inspection daily x 4 weeks and t thereafter. Dietary Manager G o designee will report findings to t QAPI committee for as long as t committee deems necessary.	er kitchen found it to found it to r G provided e regarding the two-wee lanager G ks on the n return lanager G ks on the equirment. anager G or an convection ek deep oven hen weekly r her he guarterly	

Facility ID: 0004

If continuation sheet Page 23 of 23

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		435096	B. WING		11/06/2024	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	HOME SIOUX FALLS			1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
E 000	Initial Comments		E 000	0		
	CFR Part 482, Subp Emergency Prepared	ey for compliance with 42 art B, Subsection 483.73, dness requirements for Long was conducted on 11/6/24. x Falls was found in				
	n Herrboldt	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	Administrator	(X6) DATE 11/27/2024	

program participation.

Event ID: OGA521

If continuation sheet Page 1 of 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED
		435096	B. WING			11/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105	PCODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE	
K 000	INITIAL COMMENTS		ĸ	000		
	(a)&(b), requirements	ce with 42 CFR 483.90				
LABORATORY	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
	Herrboldt			Administrator		11/27/2024
		sterisk (*) denotes a deficiency which the ins on to the patients. (See instructions.) Exce				
follow has the st				the shows findings and slope of some	te a constant de la c	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 11/21/2024 FORM APPROVED

If continuation sheet 1 of 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION						SURVEY
			B. WING			
		10677			11	/07/2024
AME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ETHANY	HOME SIOUX FALLS		HOLLY AVENUE FALLS, SD 57105			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLE DATE
S 000	Compliance/Noncom	pliance Statement	S 000			
	Administrative Rules 44:73, Nursing Facili	or compliance with the of South Dakota, Article ties, was conducted from /24. Bethany Home Sioux ompliance.				
S 000	Compliance/Noncom	pliance Statement	S 000			
	Administrative Rules 44:74, Nurse Aide, re training programs, wa	or compliance with the of South Dakota, Article equirements for nurse aide as conducted from 11/5/24 hany Home Sioux Falls was				
	IRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE

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STATE FORM