STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

(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
F0000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/20/25 through 10/21/25. Areas surveyed included accident hazards related to the use of mechanical lift equipment for resident transfers and resident safety belt use with the whirlpool bath chair. Bethany Home - Brandon was found to have past noncompliance at F689.	F0000		
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, observation, record review, and policy review, the provider failed to ensure certified nursing assistant (CNA) L had used the whirlpool bath chair safety belt according to the provider's policy during resident 6's bath, CNA K had used the whirlpool bath chair safety belt according to the provider's policy during resident 7's bath, and CNA M had followed resident 4's care plan regarding safe transfers with the mechanical lift equipment. Resident 6 fell out of the bath chair and sustained a pelvic fracture. Resident 7 fell out of the bath chair and sustained multiple fractures to her lower spine, pelvis, and tibia. Resident 4 was transferred using the wrong mechanical lift equipment according to her care plan, and sustained leg bruising and a tibia fracture. Residents 4, 6, and 7 were hospitalized related to their injuries. This citation	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hunter Winkleplleck	Administrator	11/25/2025

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F0689 SS = G	Continued from page 1 is considered past noncompliance based on review of the corrective actions the provider implemented immediately following the incidents. Findings include: A. 1. Review of the provider's 8/14/25 final FRI submitted to the SD DOH revealed that on 8/11/25 at around 7:15 a.m., CNA L was giving resident 6 a bath in the whirlpool tub. CNA L had removed the whirlpool chair safety belt to cleanse the resident's skin folds and turned away from the resident to grab the nail clippers. While she was turned away, resident 6 fell forward out of the bath chair. Registered nurse (RN) N was alerted and came to the whirlpool room to assess the resident. Her statement indicated that the bath chair was at her waist height and the brakes were not engaged. RN N assessed resident 6 for injuries and noted that her left elbow was reddened and started to swell. Resident 6 reported she was in pain but was unable to verbalize where she was having pain. Four staff members were able to lift her from the floor using the full body mechanical lift (a device with a sling used to transfer a person's full body). Staff later attempted to transfer the resident with the stand aid mechanical lift (a device used to assist a person from a seated position to a standing position), but resident 6 displayed pain and difficulty with standing. Resident 6's power of attorney (POA) was notified of the incident and agreed to have X-ray imaging of the resident performed at the facility. The X-ray showed that the "left part of [resident 6's] pelvis was clearly broken." Resident 6 was sent to the local emergency department, where it was confirmed that she had a "pubic rami [the bones that connect the front of the pelvis to the hip bones] fracture that was nonsurgical [would not be repaired by surgery]." The provider suspended CNA L on 8/11/25 pending their internal investigation. The provider reviewed the policy for bathing on 8/11/25 and documented that "all nursing staff were educated on [8/14/25] or prior to their next working shift." A bathing audit was started on 8/15/25 "which would include ensuring the bath belt is in place. Audit expectations are 10 audits for 2 weeks and 5 audits for 2 weeks." CNA L was terminated on 8/15/25 as she "admitted to	F0689		

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F0689 SS = G	Continued from page 2 removing the bath belt prior to being ready to transfer [resident 6]." 2. Review of resident 6's electronic medical record (EMR) revealed that she sustained a pubic rami fracture because of the fall from the whirlpool bath chair on 8/11/25. She was sent to the emergency department on 8/11/25 and returned to the facility on 8/13/25. Her primary care provider (PCP) ordered "Oxycodone HCl [hydrochloride] Oral Tablet 5 MG [milligrams] Give 2.5 mg by mouth every 4 hours as needed [PRN] for Pain" that started on 8/14/25. She received that PRN pain relief medication 17 times in August, one time in September, and had not received that medication in October through the end of the survey. 3. Observation and interview on 10/20/25 at 4:17 p.m. with resident 6 revealed that she was resting in bed. Her bed was in the lowest position to the floor, and there was a cushioned floor mat next to her bed. She could not remember falling out of the bath chair. She denied any current pain. 4. Review of the provider's 8/15/25 final FRI submitted to the SD DOH revealed that on 8/14/25 at around 6:30 a.m., CNA K was giving resident 7 a bath in the whirlpool tub. CNA K removed the whirlpool chair safety belt to dry the resident off with a towel. CNA K turned around to throw the towel in the basket and resident 7 leaned forward and fell out of the chair. Licensed practical nurse (LPN) O came to evaluate the resident for injuries. CNA K stated that "[resident 7] definitely hit [her] head and landed on [her] knees." Resident 7 had an abrasion and bruising on the top of her head and reported that her right knee was hurting. Resident 7's right kneecap "appeared to be sitting more lateral [to the side] than what would be normal." The resident was not able to extend her knee. Resident 7 was sent to the local emergency department where "it was determined she has a hip and pelvic fracture and a possible knee fracture." CNA K was provided with "immediate education on bath chair use and safety." As stated in the FRI from the 8/11/25 incident with resident 6, the provider educated all staff on bath chair use and safety on 8/14/25 "or prior to their next working shift."	F0689		

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F0689 SS = G	Continued from page 3 In addition to the staff education, the environmental services director assessed all bath chairs on 8/15/25 “and determined [the bath chairs] to be in functional working order.” The audits to verify bathing safety compliance were a continuation of the above-described audits initiated for the 8/11/25 FRI regarding resident 6’s fall. 5. Review of resident 7’s EMR revealed that she fell out of the bath chair on the morning of 8/14/25 and was transferred to a local emergency department. She readmitted to the facility on 8/19/25 with new diagnoses of “fracture of unspecified parts of lumbosacral spine [the lower portion of the spine] and pelvis,” “unspecified fracture of unspecified acetabulum [the socket of the hip bone],” and “displaced bicondylar fracture of right tibia [two fractures at the top of the tibia, below the kneecap].” Upon readmission on 8/19/25, she was noted to have an abrasion and bruising on the top of her head, scattered bruising to her upper extremities, and multiple surgical incisions to her pelvic and pubic areas. She experienced increased pain and anxiety after she readmitted to the facility. Resident 7’s PCP made several medication changes such as hydroxyzine, buspirone, duloxetine, and lorazepam for anxiety, and oxycodone, tramadol, methadone, acetaminophen, lidocaine patches, diclofenac external gel, and buprenorphine transdermal patches for pain management. Resident 7 continued to decline in health status, was suspected to have contracted an infection, and was prescribed antibiotics on 9/2/25. She was transferred to the local emergency department on 9/3/25 due to throwing up and low oxygen saturation levels. She was placed on intravenous antibiotics in the hospital due to suspected pneumonia and a urinary tract infection. She returned to the facility on 9/3/25. Resident 7 was admitted to hospice services on 9/4/25 and was discharged to a local inpatient hospice provider on 9/10/25. 6. Interview on 10/20/25 at 4:50 p.m. with CNAs D and J revealed that they were aware of resident 6’s fall that	F0689		

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F0689 SS = G	Continued from page 4 occurred on 8/11/25 and resident 7's fall on 8/14/25. They confirmed there was education provided "recently" on proper bathing procedures and the use of the whirlpool chair safety belt. They indicated that the policy was to have two staff members assisting with all resident transfers when using the mechanical lift equipment. 7. Interview on 10/20/25 at 4:54 p.m. with CNA F revealed that the bathing education involved in-person demonstrations on how to properly use the safety strap on the whirlpool chair safety belt. She stated that it was facility policy to have two staff members present for all resident transfers when using the mechanical lift equipment. 8. Interview on 10/21/25 at 11:18 a.m. with DON B revealed that CNA L's employment was suspended on 8/11/25 after resident 6's falling incident, pending their investigation per their policy. Verbal education was provided by the nursing managers to all nursing staff on 8/14/25 on proper use of the whirlpool chair safety belt. The leadership team met on 8/11/25 and reviewed and revised the bathing policy and procedures and started to develop a formal education and audit plan. On 8/14/25, each neighborhood nurse leader held a meeting with the staff present on each unit and demonstrated proper bathing procedure education with an emphasis on using the safety belt. The staff who were not present at the facility on 8/14/25 were provided education by phone to ensure everyone received the education timely. The audits consisted of observations of staff performing resident baths. The audits were completed for 10 observations for two weeks, then five audits for an additional two weeks. After that time, she submitted the audit data to the provider's quality assurance and performance improvement (QAPI) committee for review and recommendations. The QAPI committee recommended to discontinue those audits at that time due to sufficient compliance with the provider's bathing policy. 9. Review of the provider's bathing incident investigation documentation confirmed that the director of nursing (DON), assistant director of nursing (ADON), and the neighborhood leaders (NHLs) provided education to all nursing staff related to proper bathing	F0689		

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F0689 SS = G	Continued from page 5 procedures and the use of the whirlpool chair safety belt on 8/14/25. Staff who received that education in-person signed documents confirming the education was provided. Staff who were not present for the education were called and provided the education over the phone by the DON, ADON, and NHLs on 8/14/25. The DON, ADON, and NHLs performed observational audits of several staff across multiple shifts performing resident baths to ensure proper safety procedures. If the resident baths were already completed by the time of the audit, the CNA demonstrated the steps to performing a resident's bath to the auditing staff person. The audits started on 8/15/25 and lasted four weeks as described in the above FRIs. Review of the provider's QAPI committee documentation revealed the committee reviewed the audit data at the conclusion of the four weeks of observations and recommended to discontinue the audits. 10. The provider's 8/14/25 implemented actions to ensure the deficient practice does not reoccur was confirmed on 10/21/25 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding proper bathing techniques and the use of the whirlpool bath chair safety belt, interviews revealed staff understood the education provided regarding those topics, observations of resident transfers and bathing revealed no concerns, and a review of the provider's follow-up audits revealed substantial compliance. Based on the above information, noncompliance at F689 occurred on 8/11/25 and 8/14/25. Based on the provider's implemented corrective action for the deficient practice confirmed on 10/21/25, the noncompliance is considered past noncompliance. B. 1. Review of the provider's 9/25/25 FRI submitted to the SD DOH regarding resident 4 revealed on 9/18/25 at around 3:00 p.m., CNA M failed to transfer the resident with another staff person and had not used the mechanical total lift, as instructed in the resident's comprehensive care plan, while CNA M was transferring the resident from the resident's wheelchair to the bath chair, resulting in resident 4 sustaining an acute fracture of the proximal tibia of her lower left leg. On 9/18/25 at 6:45 p.m., CNA M had gotten resident 4	F0689		

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F0689 SS = G	Continued from page 6 ready for bed and noticed she had a red bruise on her left anterior lower leg. On 9/18/25 at 6:51 p.m., LPN G was alerted by CNA M of the bruise and resident 4 was assessed at that time. Her statement indicated the bruise was red and purple in color with no open areas or swelling noted. LPN G asked resident 4 if she had pain to her left lower leg, and the resident stated, “yes.” Resident 4 had an active order for Tylenol 1000 milligrams (mg) to be given at 8:00 p.m. and that was administered to the resident for the pain. LPN G indicated she completed a dressing change on resident 4 earlier in the day, and did not notice any concerns with the resident’s leg at that time. The dressing change was not on resident 4’s left lower leg, but did allow visualization of her leg at the time of that dressing change. Resident 4’s primary physician, her son, DON B, ADON C, and the resident’s hospice provider were notified of the incident. Resident 4 was receiving hospice care through a local hospice provider. On 9/19/25, DON B spoke with CNA M. CNA M denied any concerns with resident 4’s transfer when she gave the resident her whirlpool bath on 9/18/25. On 9/21/25, resident 4 was observed having face grimacing and was grabbing at her left lower leg when she was transferred from her wheelchair to bed after lunch with the use of the mechanical total lift and two staff members. The resident was assessed, and a large dark purple bruise was noted below her left knee and extended down to her left ankle. A bounding pedal (feet) pulse, and circulation (presence and strength of blood flow) was noted to be present in each toe. Administrator A and DON B interviewed CNA M on 9/25/25 and CNA M revealed she had transferred resident 4 alone with the use of the mechanical total lift from the resident’s wheelchair to the tub chair and back to her wheelchair after she had given the resident a bath on 9/18/25. Administrator A had asked CNA M why she had used the mechanical total lift alone, as the provider’s policy was that two staff members must assist with the use of the mechanical total lift for resident transfers. Administrator A had informed CNA M that she was suspended effective immediately pending further investigation.	F0689		

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F0689 SS = G	Continued from page 7 During the investigation process, Administrator A had been informed that CNA M had verbally stated she had used the mechanical stand aid to transfer resident 4 and not the mechanical total lift. On 9/30/25, administrator A informed CNA M that her employment at the facility was terminated. On 9/29/25, skin assessments had been completed on all facility residents for potential injuries from improper mechanical lift use. No additional resident injuries were found. The provider educated all staff on the mechanical total lift and stand aid policy on 9/18/25 or prior to their next working shift. In addition to the staff education, staff competencies for total lifts were completed with full-time and part-time staff by 10/10/25 and prior to their next working shift for any as needed (PRN) staff and seasonal staff who did not receive the education before 10/10/25. Audit expectations were for five audits per week for one month. After one month, the results of the findings would be brought to QAPI committee for review and recommendations. 2. Review of resident 4's EMR revealed she was under the care of a local hospice provider and received Morphine 0.25 milliliters (ml) by mouth every hour as needed. On 9/22/25, new orders were received from her hospice provider to administer Morphine 0.25 ml by mouth every four hours scheduled and to continue with the previous as needed Morphine order for the resident's pain. On 9/23/25, resident 4 was seen by her primary care physician and an order was received for an X-ray of the lower left extremity of tibia (shin bone) and fibula (calf bone). On 9/25/25, X-ray results revealed an acute (sudden onset) fracture (break in bone) of the proximal tibia (upper part of the shinbone that forms the bottom of the knee joint) of her lower left leg. 3. Observation and interview on 10/20/25 at 4:14 p.m. with CNA I and CNA H revealed the use of the total lift with resident 1 required two staff for the transfer. CNA H stated she orientated new CNAs and observation of proper use of mechanical lifts was required by new staff before their orientation was completed.	F0689		

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F0689 SS = G	Continued from page 8 4. Observations on 10/20/25 at 4:34 p.m. of CNAs D, F, and J revealed they were using the stand aid mechanical lift to assist resident 6 up from the bed. CNAs D and F helped resident 6 with sitting upright from the laying position. All CNAs helped apply the safety straps onto resident 6 to use the stand aid mechanical lift. CNAs D and J then transferred resident 6 to use the toilet. They helped the resident clean up and get dressed for supper. The resident did not display any signs or symptoms of pain during the process. There were no observed concerns with how the CNAs were utilizing the stand aid mechanical lift. 5. Observation and interview on 10/21/25 at 8:30 a.m. with CNA H and CNA K revealed two staff must assist with the use of the mechanical stand aid. Resident 2 had been transferred from his wheelchair to the tub chair. The sling used with the mechanical stand aid was properly placed around the resident's back and underneath his arms. The safety straps had then been attached to the mechanical stand aid prior to the transfer. Once resident 2 had been seated on the tub chair, the sling had been taken off and the safety belt on the tub chair was applied around the resident's waist and properly fastened. The safety belt remained around the resident's waist until he had been fully redressed after he received his bath. The mechanical stand aid sling had then been reapplied prior to the transfer. Both CNAs indicated they recently received additional education on the usage of the mechanical total lift and stand aid. 6. Interview on 10/21/25 at 8:45 a.m. with resident 2 revealed two staff have always been present when he was transferred with the use of the mechanical stand aid. 7. Interview on 10/21/25 at 10:45 a.m. with DON B revealed all unknown injuries to residents must be reported to the SD DOH, such as the incident that had occurred on 9/18/25 for resident 4. 8. Interview on 10/21/25 at 10:58 a.m. with LPN G revealed she was informed of the bruise noted to resident 4's left lower leg by CNA M on the evening of 9/18/25. She had indicated the bruise looked fresh with a red color noted to it. She stated resident 4's primary physician, her son, DON B, ADON C, and resident 4's hospice provider was notified of the incident.	F0689		

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F0689 SS = G	Continued from page 9 9. Interview on 10/21/25 at 11:32 a.m. with ADON C revealed she received a call from LPN G on 9/18/25 reporting that resident 4 had an unknown injury noted to her left lower leg. She indicated that LPN G reported it was a new bruise that was red in color. 10. Interview and observation on 10/21/25 at 10:45 a.m. with DON B revealed documentation that included names of all full-time and part-time staff and PRN and seasonal staff. Each staff member who had completed their competency for the mechanical total lift and stand aid by 10/10/25 had an “X” next to their name. For any PRN and seasonal staff, they were required to complete their competency prior to their next working shift. 11. Interview with resident 4 was not completed during the survey, as she was not able to provide viable information. 12. Interview with Administrator A was not completed, as he was unavailable during the survey. 13. Interview with CNA M was not completed, as her employment at the facility was terminated on 9/30/25, prior to the survey. 14. Interviews with other random resident throughout the survey from 10/20/25 to 10/21/25 revealed that there were no concerns with staff interactions or transferring with the mechanical lift equipment. 15. On 10/21/25, documentation was provided from the provider that revealed CNA M had received education on the limited lift agreement on 7/15/25, at the time of her orientation. On 7/18/25, CNA M had signed the floor training checklist that she acknowledged she received proper training on the mechanical total lift and stand aid. 16. Review of the provider’s undated Bethany Home: Using a Mechanical Lifting Machine Policy revealed “at least 2 nursing assistants are needed to safely move a resident with a mechanical lift.”	F0689		

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F0689 SS = G	Continued from page 10 17. The provider's 9/25/25 implemented actions to ensure the deficient practice does not reoccur was confirmed on 10/21/25 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding safe resident transfers with the use of the mechanical total lift and stand aid, interviews revealed staff understood the education provided regarding those topics, observations of resident transfers and bathing revealed no concerns, and a review of the provider's follow-up audits revealed substantial compliance. Based on the above information, noncompliance at F689 occurred on 9/18/25. Based on the provider's implemented corrective action for the deficient practice confirmed on 10/21/25, the noncompliance is considered past noncompliance.	F0689		