STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Of Beresford	**606 W CEDAR , BERESFORD, South Dakota, 57004**

(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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/25 through 8/13/25. Bethesda of Beresford was found not in compliance with the following requirements: F695, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/11/25 through 8/13/25. The area surveyed was quality of care/treatment related to a resident who eloped. Bethesda of Beresford was found not in compliance with the following requirement: F689.	F0000		
F0689 SS = D	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 South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, observation, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (40) who eloped (left the facility without staff knowledge). Findings include: 1. Review of the provider's 7/9/25 submitted SD DOH FRI regarding resident 40 revealed:	F0689	Unable to correct past noncompliance. This had the potential to affect Residents with similar BIMS (Brief Interview for Mental Status) and Elopement Assessment scores. All staff will be reeducated on elopement policy and procedures by Administrator or designee by 09/27/2025 or at start of next shift if after. Administrator, and IDON or designee will review and revise any related Elopement policy and procedures as necessary. IDON or designee will present the reviewed and revised policy to with the QAPI team on 09/16/2025. IDON will be educated on documentation and assessment timeliness on Elopements by Administrator or designee by 09/27/2025 or at start of next shift if after. Nightly Exit Door Checks policy and procedure will be updated by 09/27/2025. IDON or designee will educate nursing staff by 09/27/2025 or at start of next shift if after.	09/27/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Britney Senger	Administrator	09/09/2025

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F0689 SS = D	Continued from page 1 *On 7/9/25 at 1:44 p.m. resident 40 was found on the east side of the building by certified nursing assistant (CNA) M. *CNA M brought her back into the facility and notified the registered nurse (RN) N. *Staff determined she had exited the facility through the east door in the therapy department. *The door leading into the therapy department had been propped open and the east door leading to outside was unalarmed. *She did not recall leaving the facility and her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits. *Therapy staff were educated that they needed to keep the door to the therapy department shut. *A sign had been placed on the door indicating to staff to keep it shut at all times. Review of resident 40's electronic medical record (EMR) revealed: *She was admitted to the facility on 6/23/25. *She had a diagnosis of paranoid schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and generalized anxiety disorder. *Her Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated she had severe cognitive impairment. *Her 6/23/25 elopement evaluation indicated she was not at risk for elopement. *She needed supervision while walking and wandered the facility without a purpose. *She did not use assistive devices for walking. *She occasionally pushed on the exit doors until they alarmed and would forget that she needed help when exiting the facility. *Her progress notes revealed she wandered consistently in the hallways and would push on exit doors, which, if	F0689	IDON or designee will audit the Elopement Procedures process, and 3 Residents who were identified to be potentially affected by evaluating the Residents BIMS, Elopement Assessments and Care Plans, and completion of Nightly Exit Door Checks weekly for 4 weeks and monthly for 2 months. IDON or designee will report findings at monthly QAPI meetings until Audit is complete, and QAPI determines issue no longer needs to be addressed.	

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F0689 SS = D	Continued from page 2 alarmed, would sound an alarm to alert staff that the door had been opened. -On 6/23/25 at 2:06 p.m. the therapy department notified the nursing staff she had gotten into the therapy room and had tried to use the exit door. -On 7/1/25 and 7/5/25 she had set off the door alarms. -On 7/9/25 at 12:56 p.m. she had attempted to exit the 100-hall door. -On 7/9/25 at 2:10 p.m. she had eloped and was found walking in the parking lot towards the road. -On 7/10/25 she attempted to exit the 100-hall door. -On 7/12/25 she attempted to exit the front door with another resident. -On 7/13/25 she had been at the 100-hall door and stated to staff that you could push on the door for 10 seconds and it would open because the sign on the door said so. -On 7/16/25 and 7/18/25 she had set off the door alarms. *On 7/25/25 she was sent to the hospital for a mental health evaluation and placed on a mental health hold. -The resident had been discharged and was no longer at the facility. Observation on 8/11/25 at 3:35 p.m. revealed the door to the therapy room had a sign on it stating to keep it shut at all times. Observation on 8/12/25 at 1:55 p.m. revealed the door to the therapy room had been propped open. Observation on 8/13/25 at 1:12 p.m. revealed that the door to the therapy room had been propped open. Interview on 8/13/25 at 10:44 a.m. with CNA H regarding resident 40 revealed she wandered the hallways constantly and would set off the door alarms. Interview on 8/13/25 at 10:53 a.m. with RN I regarding	F0689		

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F0689 SS = D	Continued from page 3 resident 40 revealed: *She did not seem to try to exit the facility in the beginning of her stay. *She had eloped through the therapy department door. *The therapy department had been educated to keep their door shut. *There was a key hanging on the wall beside the door to get into the therapy room. *Resident 40 was no longer at the facility because she needed a mental health evaluation. Interview on 8/13/25 at 1:53 p.m. with interim director of nursing (IDON) B and administrator A revealed: *The door to the therapy department had been propped open the past two days due to a contracted worker installing an alarm to the therapy department's east door exit. *The administrator had told that worker that he needed to keep the door closed. *The administrator confirmed that she had educated the therapy department about keeping the door closed. *They stated they thought that the elopement occurred because it was a system failure, which was corrected by installing an alarm on the door inside the therapy department. *The administrator confirmed that all other doors in the facility were alarmed. *IDON B did not think that resident 40 had exit seeking behaviors because she had never tried to pack her bags or state to staff that she wanted to leave the facility. *IDON B believed that to determine if residents were at risk for elopement, exit seeking behaviors needed to be "intentional." *IDON B confirmed that resident 40 was not re-evaluated for risk of elopement after she eloped because she did not think it was necessary. *IDON B confirmed that interventions for elopement had not been documented in resident 40's care plan after	F0689		

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F0689 SS = D	Continued from page 4 she had eloped. Review of the provider's undated Elopement policy revealed: *"To assess and identify residents at risk of elopement. To provide a system of documentation for the prevention of elopement. To minimize risk of elopement through individualized interventions. To identify a plan in the event of a resident elopement." *"1. At the time of admission, identify the resident who is at risk for elopement on the initial/temporary care plan with interventions specific to the resident to minimize individual risk. This is to be reviewed again quarterly and PRN [as needed]."	F0689		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, policy review, and manufacturer's guideline review, the provider failed to ensure: *Oxygen equipment for two of two sampled residents (3 and 28) who required the use of supplemental oxygen was kept off the floor and appropriately serviced. *Infection control practices had been followed by three of three staff members (registered nurse (RN) J, certified nursing assistant (CNA) K, and CNA L) to minimize the risk of contamination to the oxygen tubing, for one of one sampled resident's (3) who required the use of continuous oxygen. *One of one sampled resident (3) received oxygen as ordered by the physician. *One of one sampled resident's (28) continuous use of oxygen at night was addressed in the resident's care	F0695	Unable to correct past noncompliance. This had the potential to affect any Residents who utilizes oxygen concentrators, portable tanks or nebulizers. Resident 3 O2 tubing and nasal cannula tubing on both concentrator and portable tank were replaced and dated on 08/13/2025. The humidifier was filled with water on 08/13/2025. A new jug of distilled water was also placed in Resident 3 room. The filter on the back side of the concentrator was replaced on 08/13/2025. Service of all concentrators and nebulizer equipment was completed on 09/02/2025. Service was provided by Medical Equipment Services, Inc. Resident 28 care plan was updated to reflect use of supplemental oxygen. Oxygen concentrator policy will be reviewed and updated as necessary by IDON or designee. IDON or designee will present reviewed and updated policy to QAPI meeting on 09/16/2025. IDON or designee will educate Nursing Department Staff on reviewed and revised policy by 09/27/2025 or at start of next shift if after. IDON or designee will educate Nursing Department Staff on proper changing of tubing, discarding potentially contaminated oxygen equipment, filling humidifier, use of oxygen as ordered by Physician and included in resident CarePlan, and any necessary oxygen policy updates by 09/27/2025 or at start of next shift if after.	09/27/25

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F0695 SS = E	Continued from page 5 plan. Findings include: 1. Observation and interview on 8/12/25 at 9:05 a.m. with resident 3 while he was in his bed in his room revealed: *He communicated with sounds and gestures. *He had an oxygen (O2) concentrator (a device that filters room air into purified oxygen) next to his dresser, near the bathroom, which contained: -An undated O2 tubing and nasal cannula tubing (flexible tubing with prongs that delivers oxygen through the nose). -A humidifier bottle that did not contain any liquid. -An orange medical supply service sticker indicated that the O2 concentrator had been serviced on 7/30/24 and was due for service on "7/25." *The filter on the back side of the concentrator was missing. *An open jug of "purified water" dated "6-9" was on the table next to the O2 concentrator, which contained approximately one inch of water. *His wheelchair, located in the bathroom, had a portable O2 tank on it with an undated O2 nasal cannula tubing attached to it hanging towards the floor. Review of resident 3's electronic medical record (EMR) revealed: *He was admitted on 10/1/2018. *His diagnoses included emphysema (a chronic lung disease), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it hard to breathe) (COPD), obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and dementia (a group of symptoms affecting memory, thinking, and social abilities). *His 7/31/25 Minimum Data Set assessment indicated his speech was unclear, with slurred or mumbled words, and he sometimes made himself understood with limited	F0695	IDON or designee will audit all Residents utilizing oxygen concentrators or nebulizers for proper labeling of tubing, filling of humidifiers, oxygen is being used as order by Physician and included in CarePlan, and cleaning of equipment per manufactures guidelines twice weekly for 4 weeks and twice monthly for 2 months. IDON or designee will present the findings of these audits to monthly QAPI meetings until Audit is complete, and QAPI determines issues no longer need to be addressed.	

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F0695 SS = E	Continued from page 6 ability to make concrete requests. *A 2/24/23 physician order indicated "Change oxygen and/or nebulizer [a device that converts liquid medication into an inhalable mist] equipment and clean filters one time a day every 2 [two] weeks on FRI [Friday] for infection control." *A 12/20/24 physician's order indicated "ensure that oxygen is in place and oxygen in tank two times a day." *A 2/19/25 physician order indicated "Oxygen continuously at 3L [liters] per nasal cannula…Keep oxygen levels above 90% [percent]." *His current care plan included: -"I have COPD and acute on chronic respiratory failure." -"I have obstructive sleep apnea and I wear oxygen at night and throughout the day to maintain my oxygen SATs [saturation level]." -"I have an oxygen tank in my wheelchair. I sometimes do not want to wear the oxygen and will take it off at my discretion. I often will become distressed by this decision. Please encourage me to always keep it on." Observation and interview on 8/13/25, starting at 9:30 a.m. in resident 3's room revealed: *Resident 3 was in bed and was not wearing his oxygen. His undated O2 nasal cannula tubing was on the floor in front of his O2 concentrator. *At 9:34 a.m. CNA K and CNA L entered resident 3's room. -CNA L shut off resident 3's O2 concentrator, picked the nasal cannula up off the floor, coiled up the nasal cannula tubing, and placed it in a blue bag that hung from his dresser drawer. --CNA K explained that the blue bag was where resident 3's oxygen nasal cannula was to be stored when he was not wearing it between uses. *CNA K stated that the red spots on resident 3's pillow and t-shirt were blood from his bloody nose. She thought that his nose was dry from his oxygen use. *CNA L and CNA K assisted resident 3 with personal	F0695		

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F0695 SS = E	Continued from page 7 hygiene, using the toilet, and getting dressed, and then assisted him into his wheelchair. -Resident 3 had not worn his oxygen during any of those activities. *Resident 3's nose bled off and on. He wiped his nose several times with his hand, and CNA K used a tissue and blotted blood from his left nostril. *Once seated in his wheelchair, resident 3 communicated with CNA L and CNA K with grunting sounds and gestures. He pointed to his O2 concentrator and touched his face several times. He took deep breaths, leaned forward, and appeared frustrated. *CNA K stated that she needed a new oxygen tank for resident 3's wheelchair and that she would put his oxygen on as soon as she changed that tank. She then left his room while pushing him in his wheelchair. Observation and interview on 8/13/25 at 10:01 a.m. with CNA K and resident 3 in the oxygen storage room revealed: *At 10:02 a.m. CNA K placed the nasal cannula that had been attached to the portable oxygen tank on resident 3 and turned it on. She stated he received three liters of oxygen. -Resident 3 had been without oxygen for at least 30 minutes. *CNA K confirmed that resident 3 was to always wear his oxygen, that she had not tried to put his oxygen on him before that time, but that he was known to remove his oxygen when he was "agitated." *CNA K did not know how often the nasal cannula tubing was to be replaced because the nurse did that. *She did not monitor resident 3's oxygen saturation (percentage of oxygen in the blood) levels during the above observation. Observation and interview on 8/13/25 at 10:44 a.m. with RN J in resident 3's room revealed: *She stated that resident 3's humidifier had been empty that morning when she filled it with distilled water. *Residents' O2 tubing, nasal cannulas, humidifiers and	F0695		

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F0695 SS = E	Continued from page 8 concentrator filters were to be changed every two weeks and documented on the TAR. *She removed resident 3's nasal cannula from the blue bag and confirmed that the nasal cannula was not labeled. *After having been informed of the above observations of CNA L having picked that nasal cannula up off the floor, coiled it up, and placed it in the blue bag, RN J stated that resident 3 often removed his nasal cannula. She stated that earlier that morning, she had picked it up off his fall mat, and he had allowed her to put it back on. RN J then placed the nasal cannula back into the blue bag that hung from his dresser handle. *She expected CNA L and CNA K to have attempted to put resident 3's nasal cannula back on him and to have encouraged him to wear his oxygen because it was ordered by the physician to be on continuously. *RN J confirmed that there was no filter on the back of resident 3's concentrator and that the service sticker indicated it had been due for service on "7/25." She did not know who serviced the concentrators. 2. Observation and interview on 8/12/25 at 9:39 a.m. with resident 28 and two family members in her room revealed: *Resident 28 wore oxygen every night and occasionally during the day when she had difficulty breathing. -She felt that the facility was very dry and she often had a dry nose and throat. *Resident 28's family member stated they had put a large plant in resident 28's room to "add some moisture." *There was an O2 concentrator next to resident 28's bed. -An orange medical supply service sticker indicated that the concentrator had been serviced on 7/30/24 and was due for service on "7/25." *There were two one-gallon jugs of distilled water behind resident 28's recliner. *Resident 28 stated that she had an O2 humidifier on the O2 concentrator when she came to the facility, but	F0695		

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F0695 SS = E	Continued from page 9 there had been a problem with that humidifier. The humidifier had been removed, but it had not been replaced. Review of resident 28's EMR revealed: *She was admitted on 1/13/25. *Her diagnoses included chronic bronchitis (a respiratory condition with a persistent cough) and COPD. *Her 7/8/25 BIMS assessment score was 13, which indicated she was cognitively intact. *A 2/13/25 physician order indicated "Oxygen at 1L/NC [1 liter per nasal cannula]at bedtime for [to] Keep SpO2 [oxygen saturation levels] > [greater than] 90%." *Her care plan did not address her use of supplemental oxygen. 3. Interview on 8/13/25 at 11:00 a.m. with interim director of nursing (IDON) B and administrator A revealed they had been aware that the O2 concentrators had been due for services. Administrator A had planned to call to schedule that service but had forgotten. 4. Observation on 8/13/25 at 11:05 a.m. with IDON B in resident 3's room revealed IDON B: *Stated resident 3's O2 concentrator was provided by the Veterans Administration, but was to be serviced by the facility. *Confirmed resident 3's concentrators had been due for service on "7/25." *IDON B expected: -Resident 3's O2 humidifier to have been refilled, when empty, by a CNA or a nurse when they assisted resident 3 with putting on or taking off his oxygen in his room. --She had not been aware that resident 3 had a bloody nose or that the humidifier had been empty for two days. -Resident 3's O2 concentrator filter to have been replaced when it was missing by the facility.	F0695		

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F0695 SS = E	Continued from page 10 -CNA L to have discarded resident 3's nasal cannula tubing when it had been found on the floor and notified the nurse for a replacement nasal cannula. -CNA L and CNA K to have encouraged resident 3 to wear his oxygen during activities of dressing, using the toilet, and personal hygiene. -RN J to have discarded and replaced resident 3's nasal cannula tubing when notified that it had been on the floor. -The nasal cannula and oxygen tubing to have been changed and dated every two weeks. Observation on 8/13/25 at 11:08 a.m. with IDON B in resident 28's room revealed IDON B confirmed resident 28's concentrators had been due for service on "7/25." 5. Interview and review of resident 28's care plan on 8/13/25 at 2:52 p.m. with IDON B revealed: *Resident 28 had not required oxygen until about one month after she was admitted to the facility. *IDON B expected resident 28's use of nighttime oxygen to have been added to her care plan when she began using oxygen. *IDON B was unaware that there had been a problem with resident 28's O2 humidifier or that it had been removed. *Resident 28's use of the humidifier did not require a physician's order, and they should have replaced it. 6. Review of the provider's April 2009 Oxygen Concentrator Operator's Manual revealed: *"DO NOT operate the concentrator without the filter installed." *"Remove each filter and clean at least once a week." "Only qualified personnel should perform preventative maintenance on the concentrator." *"At a minimum, preventative maintenance MUST be performed according to the maintenance record guidelines…every 4,380 hours… (4,380 hours are equivalent to usage 24 hours a day, 7 [seven] days a	F0695		

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(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
F0695 SS = E	Continued from page 11 week for 6 [six] months." Review of the provider 1/1/2019 Oxygen Concentrator policy revealed: *"Purpose: To deliver oxygen in a safe manner. To keep oxygen equipment clean and maintained in good condition." *It was their policy to perform "nursing functions in compliance with State and Federal Regulations and with practices/procedures that are widely accepted across the nursing industry." *"Change tubing, cannula or mask and clean filters located on the concentrator every other week as schedule[d] on TAR." *"Fill humidifier jar half full of distilled water, if used." *The policy did not address discarding potentially contaminated oxygen equipment, servicing of the concentrator, following the physician's order, or care planning for the use of oxygen.	F0695		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	Unable to correct past noncompliance. This had the potential to affect all Residents. Food Preparation/Food Storage and Hand Hygiene policy was reviewed and revised by Administrator on 08/28/2025. Reviewed and revised policy will be present to QAPI meeting on 09/16/2025 by Administrator or designee. Administrator or designee will create proper temperature taking policy and procedure and audit checklist for Dietary Department. Review of created policy and procedure will be completed by the QAPI team 09/16/2025. Education to the Dietary Department staff will be completed by 09/27/2025 or at next shift if after. Administrator or designee will educate Dietary Manager and all other dietary staff on documentation of cleaning tasks, proper temperature taking of food/liquid and hand hygiene by 09/27/2025.	09/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/13/2025

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Bethesda Of Beresford	**606 W CEDAR , BERESFORD, South Dakota, 57004**

(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
F0812 SS = E	Continued from page 12 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow standard food safety practices to ensure: *Documentation was completed consistently for two of two weekly scheduled cleaning tasks of the kitchen. *Temperature monitoring and documentation was completed consistently for one of one coffee machine. *One of one dietary aide (O) had washed her hands before and after serving and touching resident food items to prevent potential contamination. Findings include: 1. Observation on 8/11/25 at 1:50 p.m. in the kitchen revealed: *A binder containing the weekly kitchen cleaning schedules. *The binder indicated staff needed to initial a task when it was completed. *On the "8/4 – 8/10" weekly cleaning schedule 13 out of the 40 listed tasks were not marked complete. *On the "7/28-8/3" weekly cleaning schedule 14 out of the 40 listed tasks were not marked complete. 2. Observation on 8/11/25 at 2:45 p.m. in the dining room revealed: *A coffee machine on the counter by the kitchen doorway. *There was a temperature log taped to the side of the coffee machine dated August 25. *There were three columns labeled for breakfast, lunch, and supper to document the temperature of the coffee. -Out of the 33 areas to document coffee temperatures on that log, only 6 had documented temperatures. *There was an education sign-in sheet for hot liquid temperatures taped next to the temperature log on the	F0812	Administrator or designee will educate Dietary Manager and all other dietary staff on proper documentation of cleaning tasks. Kitchen cleaning tasks will be reviewed and updated as necessary by Administrator or designee, and reviewed changes will be present at QAPI meeting on 09/16/2025 by Administrator or Designee. Administrator or designee will educate all Dietary Staff on cleaning schedule and proper documentation of cleaning log. Administrator or designee will audit documentation of cleaning tasks, temperature of food/liquid logs and hand hygiene of dietary staff during alternating service time each audit, to ensure the appropriate hand hygiene during the serving and distributing of Resident food twice weekly for 4 weeks and then, twice monthly for 2 months. Dietary Manager or designee will report finding at monthly QAPI meetings until Audit is complete and QAPI determines issue no longer needs to be addressed.	

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F0812 SS = E	Continued from page 13 coffee machine. -It indicated staff understood how to properly check and document the temperatures of hot liquids. -It had 11 staff signatures on it. Interview on 8/13/25 at 5:00 p.m. with dietary aides F and E in the dining room regarding the coffee machine temperature sheet revealed: *Dietary aide F stated the kitchen staff no longer needed to check the temperature of the coffee machine because it had been calibrated to be at the correct temperature. *Dietary aide E stated that kitchen staff still needed to check the temperature of the coffee even though it had been calibrated. 3. Observation on 8/11/25 at 4:30 p.m. of dietary aide O in the kitchen revealed: *No hand hygiene was observed: -Before or after she checked the temperatures of food items for the supper meal. -Before or after she served the residents' plated meals during the supper meal service. -Before or after she grabbed a resident's sandwich from a plastic bag from the refrigerator and placed it on a plate with her bare hands. Interview directly after the supper meal service with dietary aide O revealed she should have performed hand hygiene before and after checking the food temperatures, before and after serving the supper meal service, and before and after touching resident food items. 4. Interview on 8/13/25 at 10:36 a.m. with dietary manager C revealed: *He expected the kitchen staff to perform hand hygiene before serving meals to residents and before and after they touched resident food items. *He expected the kitchen cleaning tasks to be completed	F0812		

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F0812 SS = E	Continued from page 14 as scheduled and the logs to be filled out to indicate those tasks had been completed daily. *The coffee machine had been calibrated to ensure it would be the correct temperature for resident safety, but he still expected staff to check the temperature with a thermometer and document those temperatures on the coffee temperature log. 5.Interview on 8/13/25 at 5:29 p.m. with administrator A revealed: *She expected staff to be checking the temperature of the coffee machine daily even if the machine had been calibrated. *The provider did not have a policy regarding how to check the temperature of food items. *She expected staff to clean the kitchen and perform hand hygiene appropriately. Review of the provider's 4/24/24 Sanitation of Dietary Department policy revealed: * "The dietary staff shall maintain the sanitation of the Dietary Department through compliance with a written, comprehensive cleaning schedule." * "A cleaning schedule shall be posted weekly for all cleaning tasks, and employees will initial tasks as completed." Review of the provider's revised 5/22/25 Hand Hygiene policy revealed: * "It is the policy of Bethesda of Beresford that all staff practice accepted hand hygiene in order to help prevent the spread of infection." * "Hand hygiene should be performed, but not limited to: -Before and after feeding residents, perform in between when feeding residents if you touch a resident, touch food, or touch utensils touched by a resident (if assisting more than one resident)."	F0812		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F0880	see next page	

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F0880 SS = D	Continued from page 15 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or	F0880	Unable to correct past noncompliance. Resident who could have potential to be affected will be identified by chart reviews which includes but not limited to review of cultures from Lab Results, new ICD-10s, skin and wound assessments and indwelling medical devices that may be placed. Resident 23 initiated Enhanced Barrier Precautions for wound on 08/14/2025. Appropriate signage for Enhanced Barrier Precautions was placed inside Resident 23 room on 08/14/2025. Resident 23 EMR was updated to reflect Enhanced barrier Precautions on 08/14/2025. Administrator and IDON will review and revise, as necessary, the Enhanced Barrier Precaution policy and procedure. The reviewed and revised policy will be present by IDON or designee at QAPI on 09/16/2025. The Administrator will educate the IDON on when precautions are to be implemented by 09/27/2025. All Nursing Staff will be educated on when to initiate and proper use of Enhanced Barrier Precautions by Administrator or designee by 09/27/2025 or at start of next shift if after. IDON or designee will audit any Resident on Enhanced Barrier Precaution to ensure appropriate use once weekly for 4 weeks and then once monthly for 2 months. IDON or designee will audit all Residents in facility one time to identify any Resident who could be affected prior to 09/27/2025. After initial completion of audit, IDON or designee will audit 3 Resident who were identified at risk for requiring EBP, to determine if the EBP outcome has changed weekly for 4 weeks and once monthly for 2 months. IDON or designee will report finding at monthly QAPI meetings until Audit is complete and QAPI determines issue no longer needs to be addressed.	09/27/2025

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F0880 SS = D	Continued from page 16 infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed by failing to place one of one sampled resident (23) with an open surgical wound on his ear on enhanced barrier precautions (EBP) (gloves and gown use when providing contact care). Findings include: 1. Observation on 8/11/25 at 3:38 p.m. of resident 23 in the hallway revealed there was a bandage on his right ear that appeared to be soaked with blood. Record review of resident 23's electronic medical record (EMR) revealed: *He was admitted to the facility on 6/13/2024. *He had a diagnoses of squamous cell carcinoma (a type of skin cancer originating from the outer layer of the skin) of the skin of the right ear and the external auricular (ear) canal. *He had seen a dermatologist to remove the area of skin cancer on his right ear. *His power of attorney (POA) (someone designated on a	F0880		

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F0880 SS = D	Continued from page 17 legal document to act on behalf of a resident) was informed that the surgical wound on his right ear would be slow healing. *A skin evaluation on 8/11/25 of his surgical wound indicated there was small amount of drainage and the wound bed appeared red with "lump-like" tissue. *There was no mention of the resident being placed on enhanced barrier precautions in his EMR documentation. Observation on 8/12/25 at 10:43 a.m. of resident 23's room revealed: *There was no sign posted inside or outside of his room that indicated he was on enhanced barrier precautions. *There was no personal protective equipment (gowns and gloves) (PPE) available inside or outside of his room for staff to use while providing his contact care needs. Observation and interview on 8/13/25 at 9:34 a.m. with registered nurse (RN) I in resident 23's room revealed: *Resident 23 had an open wound on his right ear due to a surgical procedure. *She performed hand hygiene and put on a pair of gloves. *She removed resident 23's dressing for the surveyor to observe the open wound. *She reapplied the dressing, removed her gloves, and performed hand hygiene. *She confirmed that the resident had not been on EBP since his surgical procedure on 6/19/25. Interview on 8/13/25 at 1:53 p.m. with interim director of nursing/infection preventionist B revealed resident 23 should have been on EBP due to his open surgical wound on his right ear. Review of the provider's 4/1/2024 Enhanced Barrier Precautions policy revealed: * "Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for	F0880		

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F0880 SS = D	Continued from page 18 residents known to be colonized or infected with a MDRO [multi-drug-resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.)" * "High-contact resident activities include: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care, wound care: any skin opening requiring a dressing." * "Wound in relation to this guidance, this generally includes residents with chronic wounds…" * "Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers."	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 8/12/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethesda of Beresford was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K293 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0293 SS = D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain continuous exit sign illumination for three randomly observed exit signs (400 hall number 2 and 100 hall numbers 10 & 11). Findings include: 1. Observation beginning on 8/12/25 at 12:45 p.m. revealed the exit sign (marked number 2) mounted above the cross-corridor smoke-barrier doors at the south end of the 400 wing was not lit. Further testing of the sign at that same time revealed a switch had been installed to test the battery backup circuit. That switch had been left in the off position. When that	K0293	Unable to correct past noncompliance. Maintenance Director corrected the illumination for ~~the exit signs observed down the 400 hallway on 08/13/2025~~. all exit signs observed in the facility on 08/13/2025 Administrator or designee will educate Maintenance Director on ensuring the exit and directional signs display continuous illumination. Maintenance Director or designee will audit the illumination of exit signs, at random in the building, once weekly for 4 weeks and then monthly for 2 months. Maintenance Director or designee will report findings at monthly QAPI meetings until audit is complete, and issue no longer needs to be addressed.	09/27/2025 BS 09/04/25

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
Britney Senger	Administrator	09/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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K0293 SS = D	Continued from page 1 switch was turned back to the on position to restore normal power the sign illuminated. 2. Observation beginning on 8/12/25 at 2:41 p.m. revealed the exit sign (marked number 10) mounted above the cross-corridor smoke-barrier doors at the south end of the 100 wing was not lit. Further observation at that same time revealed the exit sign on the opposing side of the smoke-barrier doors (marked number 11) revealed it too was not lit. Testing of those signs at the same time as the observations revealed switches had been installed on them to test their battery backup circuits. Those switches had been left in the off position. When those switches were turned back to the on position to restore normal power, the signs illuminated. Interview with the maintenance director at the time of the observations confirmed those conditions. He stated he was unaware when those switches had been turned off, and that he was normally the one who used the switches to test the exit signs. He further stated he normally turns the switch back to the on position after completion of the 30-second monthly test required for each exit sign.	K0293		
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K0321	Unable to correct past noncompliance. Maintenance Director corrected both " storeroom" and "electrical room" door on 08/14/2025 to ensure both doors closed and latched appropriately. Administrator or designee will educate Maintenance Director on ensuring the doors close and latch completely. Maintenance Director or designee will audit the closure of doors, at random in the building, once weekly for 4 weeks and then monthly for 2 months. Maintenance Director or designee will report findings at monthly QAPI meetings until audit is complete, and issue no longer needs to be addressed.	09/27/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 08/12/2025

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K0321 SS = E Bldg. 01	Continued from page 2 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to maintain two separate hazardous areas (the storeroom and the electrical room) as required. Findings include: 1. Observation on 8/12/25 at 10:58 a.m. revealed the room adjacent to the kitchen labeled "storeroom" was over 100 square feet and contained combustible items. That corridor door was a 1.5-hour fire-rated door and would not close and latch with the operation of the closer. Fire-rated doors must close and latch to maintain their fire ratings. 2. Observation on 8/12/25 at 11:17 a.m. revealed the room labeled "electrical room" adjacent to the laundry was over 100 square feet and contained combustible items. That corridor door was a 45-minute fire-rated door and would not close and latch with the operation of the closer. Fire-rated doors must close and latch to maintain their fire ratings. Interview with the maintenance director at the times of the observations confirmed those findings. The deficiencies affected two of numerous requirements for hazardous areas.	K0321		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/12/25. Bethesda Of Beresford was found in compliance.	E0000		

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
Britney Senger	Administrator	09/02/2025

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10595	A. BUILDING: _____ B. WING _____	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA OF BERESFORD	606 W CEDAR BERESFORD, SD 57004

(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/11/25 through 8/13/25. Bethesda of Beresford was found in compliance.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/11/24 through 8/13/25. Bethesda of Beresford was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Britney Senger

TITLE: Administrator

(X6) DATE: 09/02/2025