STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105

(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 12/16/25 through 12/18/25. Bethany Home Sioux Falls was found in compliance. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/16/25 through 12/18/25. The area surveyed was resident safety related to an elopement. Bethany Home Sioux Falls was found not in compliance with the following requirement: F689.	F0000	Resident 57 discharged from facility 9/3/25 AMA. Other residents will be identified through Wander Risk Assessment scoring. Residents that score moderate to severe will be care planned. The Social Services Director or designee will complete the Wander Risk Assessment and the Social Services Director or designee will update the care plan. 1/2/26 staff member "D" monitoring the unlocked front entrance was educated by administrator on ensuring the front entrance is monitored Monday-Friday 8:00am-4:30pm when entrance is unlocked. IDT includes: Administrator, DON, ADON, Social Services Director, nurse managers, and department managers. On 1/5/26 Administrator, DON, and IDT created "Door Monitoring and Control Access" policy to establish responsbility of door monitoring and ensuring the safety of all residents when the front entrance is unlocked. On 1/5/26 IDT reviewed, Elopement Procedure, Wandering Risk, Hazardous Areas, Devices, and Equipment, and Rounding policies and found them to be correct. 1/9/26 United Technologies (door security company) will begin installing a new system for the front entrance doors. Entrance doors will remain locked 24/7 once new system is installed. Visitors can enter a code or use a key fob to exit. All exit doors will be locked 24/7.	2/1/26
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), interview, record review, and policy review, the provider failed to ensure the safety for one of one discharged sampled resident (57) who eloped (left the facility without staff knowledge) from the front door of the facility on 8/29/25 and was reported to the facility by a community member. The facility's front door was not alarmed or monitored at that time of the resident's elopement. Findings include: 1. Review of the provider's 9/2/25 SD DOH FRI involving	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105

(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
F0689 SS = D	Continued from page 1 resident 57 revealed: *On 8/29/25 at approximately 5:10 p.m., a community member called the facility to tell staff that the resident was at their home, a block away from the facility. *The staff had last seen the resident at approximately 4:00 p.m. *According to the provider's investigation, the resident left the facility at approximately 4:06 p.m. and walked to the community member's home. She had knocked on the community member's door, and they sat with her until a facility staff member arrived. *Resident 57's goal was to go to her cousin's home, which was in that neighborhood, but she was unsure exactly where that was. She walked independently with a front-wheeled walker. *She willingly returned to the facility with the staff member. *The resident and her family had a care conference earlier that day, and the resident's sons expressed concern about the resident returning to her home independently due to her impaired cognition (mental status). *The conference earlier that day had upset resident 57, and she had expressed that to the staff member when she was picked up from the community member's home. *The resident returned to the facility at approximately 5:20 p.m. and was assisted back to her room. *The resident's son, her primary care physician, the administrator, and the director of nursing (DON) were notified of the resident's elopement. *Resident 57's vital signs after she returned to the facility on 8/29/25 were: blood pressure 128/69, pulse 80, temperature 98.0, respirations 18, oxygen saturation 95%. Her skin assessment was completed and was normal. *She was placed on 15-minute checks by staff to ensure she was in the facility and safe. 2. Review of resident 57's closed electronic medical record revealed:	F0689	1/9/26 Administrator or desginee will provide education to ALL staff on the following policies and procedures: Elopement Procedure, Wandering Risk, Door Monitoring and Control Access, Hazardous Areas, Devices, and Equipment, and Rounding policies. All education will be completed by 2/1/2026. Administrator or designee will track training on a spreadsheet. All staff are required to complete training before starting their shift. On 1/9/26 administrator will provide education to staff, residents, and families regarding new security system installation beginning 1/9/26 the security system will be completed by 2/1/26 by United Technologies. Beginning 1/9/26 administrator or designee will audit the front entrance, ensuring it is monitored at all times while doors are unlocked then after installation of new system is installed Administrator or designee will audit to ensure doors remain locked and there are no concerns with the new system. Starting 1/19/26 Administrator or desginee will audit 2x daily for 4 weeks then weekly for 2 months. Administrator or designee will report findings at QAPI and audit will be completed earlier than three months and when no concerns are found.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	**1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105**

(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
F0689 SS = D	Continued from page 2 *She was admitted to the facility on 8/5/25 to the rehabilitation (rehab) unit on Rushmore Boulevard Hall following a hospitalization for a syncope incident (fainting) with collapse. *Her discharge plan was to go to an assisted living facility after completion of skilled therapies. *Her BIMS (brief interview for Mental status) score was seven, which indicated her cognition was severely impaired. *One of her sons was her responsible party and assisted her with health decisions. *She worked with therapy services five times per week. *Her diagnoses were syncope and collapse, and Hypotension (low blood pressure). *She was discharged from the facility to her home on 9/3/25 AMA (against medical advice) with her son, who was responsible for her. 3. Interview on 12/17/25 at 2:30 p.m. with CNA (certified nurse assistant) C revealed: *He vaguely remembered an elopement incident on 8/29/25 for resident 57. *He did not think that resident 57 wandered and would exit seek. *He did rounds on residents to check on them every two hours or less. *Exit doors would be locked in the back of the building, and he did not remember responding to a door alarm that day (8/29/25). *He found out there was a resident elopement when the DON had called over the radio that she was going to pick up a resident outside of the facility. 4. Interview on 12/17/25 at 2:36 p.m. with DON B revealed: *Resident 57 had a wander assessment on admission 8/5/25 and scored a 5, which indicated moderate risk for elopement, due to mobility, and she had not verbalized a desire to leave.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105

(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
F0689 SS = D	Continued from page 3 *She had reviewed the camera footage for 8/29/25 when the resident eloped. She indicated resident 57, who used a wheeled walker independently, had left the facility going out the front door around 4:15 p.m. that day. *The front door that the resident had exited out of should have been locked and alarmed automatically at 4:30 p.m. that day. Prior to that time the front door should have been monitored by staff when it was not alarmed, but the administrative assistant (AA) D located at the front desk had stepped away to make copies in the administrative hall, and that door was not monitored or locked at the time the resident exited the facility. The AA D had not alarmed the door or notified staff to monitor the door while she stepped away. *She stated the front door should have been monitored by staff on Rushmore Boulevard Hall by camera. She could not confirm the cameras would be monitored by staff if that staff person was distracted by talking with someone or not watching the camera at all times, and she agreed that was a concern. *She stated on 8/29/25, the day of resident 57's elopement incident, a care conference with the resident and her two sons was held earlier. She stated that one of the resident's sons (responsible party) was okay for her to return to her own home alone, and the other son was not okay because she lacked awareness of her dementia (a group of symptoms affecting memory, thinking, and social abilities) and he was concerned about her safety. 5. Observation and interview on 12/18/25 at 10:30 a.m. with DON B revealed that the camera screen on Rushmore Boulevard Hall had been taken down earlier that day, 12/18/25, and was not working. She stated that the AA D had been informed to notify staff if she had to step away from monitoring the front door while it was out of order. 6. Interview on 12/17/25 at 3:35 p.m. with AA D revealed: *She had worked the day (8/29/25), when resident 57 left the building unnoticed. *She agreed she had stepped away from the desk that was located near the front door to make photocopies in the administrative hall and had left the front door	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	**1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105**

(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
F0689 SS = D	Continued from page 4 unmonitored and unalarmed during that time. *She stated she should have told someone she had left that area so that the front door would have been monitored. *Since the resident's elopement, she had been reeducated to inform staff from the administrative hall or staff from the Rushmore Boulevard Hall so someone could have monitored the front door in her absence. 7. Review of the provider's undated elopement procedure for missing resident revealed: *" To make certain that all residents are accounted for and their whereabouts always known, day and night."	F0689		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105

(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
K0000	INITIAL COMMENTS A recertification survey was conducted on 12/17/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethany Home Sioux Falls 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 K923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	12/17/2026 all combustible materials were removed from oxygen storage room to ensure the safety of all residents. On 1/8/26 IDT reviewed Oxygen Storage policy and foud to be correct. On 1/9/26 administrator or designee will provide education to all staff all staff will be educated by 2/1/26 on Oxygen Storage regulations and expectations. Environmental Services Director (ESD) or designee will audit oxygen storage room daily for 4 weeks the weekly for 2 weeks. ESD or designee will report findings at QAPI and audit will be complete when no concerns are found.	2/1/26
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K0923		

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
Amanda Peterson	Administrator	1/9/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105

(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
K0923 SS = D Bldg. 01	Continued from page 1 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to safely store medical gas as required. Combustible items were stored within five feet of the oxygen cylinders (Promise Lane oxygen storage room). Findings include: 1. Observation on 12/17/25 at 1:39 p.m. revealed combustible materials were stored adjacent to and within five feet of oxygen cylinders in the Promise Lane oxygen storage room. Two full racks of E sized oxygen cylinders were stored directly next to and within five feet of four wheelchairs and two shower chairs. Additionally, that room had clearly been marked with a sign stating "This room is used for Oxygen and O2 Supply Storage ONLY! Wheelchair and Walker STORAGE ROOM is located on SERENITY GARDENS." The storage requirements for oxygen cylinders having a minimum of five feet of separation from combustible materials was not maintained as required in that area. Interview with the maintenance director at that same time confirmed that finding. He stated he was unaware those wheelchairs and shower chairs were stored in that manner in that location. He further stated he believed nursing staff likely stored those wheelchairs and shower chairs there out of convenience due the wheelchair storage room being located further away in the other wing.	K0923	12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	**1901 SOUTH HOLLY AVENUE , SIOUX FALLS, South Dakota, 57105**

(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
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 12/17/25. Bethany Home Sioux Falls 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
Amanda Peterson	Administrator	1/9/2026

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
	10677	A. BUILDING: _____ B. WING _____	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 S HOLLY AVENUE SIOUX FALLS, SD 57105

(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 44:73, Nursing Facilities, was conducted from 12/16/25 through 12/18/25. Bethany Home Sioux Falls was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Amanda Peterson | TITLE: Administrator | (X6) DATE: 1/9/2026