STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	**1224 S HIGH ST , ABERDEEN, South Dakota, 57401**

(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 3/10/26 through 3/12/26. Bethesda Home of Aberdeen was found not in compliance with the following requirement (s): F552, F640, F657, F658, F686, F803, and F812.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or resident's representative of the risk versus benefits of medications or of alternative treatments to make an informed decision for the consent for the use of psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) before they were given for two of two sampled residents (7 and 10).	F0552	The facility's Use of Psychotropic Medication Policy was reviewed and revised by the interdisciplinary team and the medical director to include a psychotropic medication consent form. All current residents on psychotropic medications were reviewed and process put in place to make sure informed consent is obtained before initiation of new medications or a dosage increase of existing medications for all residents. Education will be provided by the DON or designee for all licensed nursing staff on the revised policy and use of the consent form by 4/10/26. PRN staff or staff on leave will be educated prior to the start of their next shift. This includes education being provided to resident or resident's representative of the risks vs benefits of medications to make an informed decision for the consent for the use of psychotropic medications before they are given. DON or designee will audit for informed consent including risk and benefit education on all new psychotropic medication orders including orders to increase the dosage of an existing psychotropic medication Audits will be done weekly for four weeks, then monthly until QAPI committee determines otherwise. These findings will be reported to the monthly QAPI committee and quarterly to the QA & A committee with medical director.	04/10/2026

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F0552 SS = D	Continued from page 1 Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed that she was admitted to the facility on 7/9/24. Her diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), unspecified psychosis not due to a substance or known physiological condition, unspecified hallucinations, delusional disorder (false beliefs and distorted views of reality), dementia (a group of symptoms affecting memory, thinking, and social abilities), depression, and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). She was unable to make decisions regarding her medical care, and her son was her power of attorney (POA, a designated person on a legal document to act on behalf of a resident). On 1/12/26, her mental health provider ordered aripiprazole 5 milligrams (mg) (an atypical antipsychotic medication that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions) at bedtime for hallucinations (to see, hear, smell, taste, or touch something that is not there). The first dose was given on 1/12/26 at bedtime. There was no documentation that resident 2's POA was notified about the new medication, if risks versus benefits were discussed, or if consent was obtained regarding the use of that psychotropic medication. The aripiprazole was discontinued on 2/11/26 as her hallucinations and other mental health symptoms were continuing without improvement. 2. Review of resident 7's electronic medical record (EMR) revealed that he admitted to the facility on 4/19/24. His 2/20/26 Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. His diagnoses included anxiety disorder, symptoms and signs involving cognitive functions and awareness, delusional disorder, and dementia with behavioral disturbance. His 3/12/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) had a focus area that read, "The resident has potential to be verbally aggressive towards residents and staff r/t [related to] Poor impulse control," with an	F0552		

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F0552 SS = D	Continued from page 2 intervention that read, "Keep family and physician updated." Another focus area read, "The resident uses antipsychotic medications [a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions] r/t behavior management" with an intervention that read, "Discuss with MD [medical doctor], family re [regarding] ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness per policy." A 11/27/24 physician's order for mirtazapine (an antidepressant) 15 mg at bedtime for anxiety was received. There was no documentation that the resident's representative was notified of the new medication order, the indication for the medication, the risk versus benefits of that medication, or alternative treatments to that medication. On 1/8/25, the mirtazapine dose was ordered to be increased to 30 mg at bedtime. There was a progress note that stated the nurse had attempted to call the resident's representative but there was no answer. There was no further documentation that the nurse reattempted to call the resident's representative or that the resident's representative returned the call. A 2/5/25 physician's order for sertraline (an antidepressant) 25 mg every day for anxiety was received. A progress note indicated resident 7's representative was notified of the new medication but there was no documentation that the risk versus benefits or alternative treatments were addressed. On 3/7/25, there was a physician's order to reduce resident 7's mirtazapine to 15 mg for 28 days, then 7.5 mg for 28 days, then 3.75 mg for 14 days, and then to stop the medication due to ineffective behavioral results. Resident 7's representative was documented as having been notified of this change. On 3/17/25, there was a physician's order to increase resident 7's sertraline to 50 mg daily and started aripiprazole (Abilify, an antipsychotic medication) 5 mg at bedtime for mood and delusions. There was no documentation that the resident's representative was notified of the new medication order, the indication for the medication, the risk versus benefits of that medication, or alternative treatments to that	F0552		

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F0552 SS = D	Continued from page 3 medication. On 4/3/25, resident 7's mirtazapine was ordered to be continued at 15 mg every day at bedtime, the scheduled reduction of that medication was to be stopped, and his Abilify was increased to 10 mg at bedtime. There was no documentation that the resident's representative was notified of the changed medication orders, the indication for the changes, the risks versus benefits of those medications, or alternative treatments to those medications. On 4/16/25, resident 7's physician ordered to increase the Abilify to 15 mg at bedtime, decrease his mirtazapine to 7.5 mg for two weeks and then stop, and to increase his sertraline to 75 mg daily for two weeks, then increase it to 100 mg daily. Resident 7's representative was notified of the changed medication orders, but there was no documentation that resident 7's representative was informed of the indication for the changes, the risks versus benefits of those medications, or alternative treatments to those medications. On 6/24/25, resident 7's sertraline increased to 125 mg daily. Resident 7's representative was notified of the changed medication order, but there was no documentation that resident 7's representative was informed of the indication for the change, the risks versus benefits of the medication, or alternative treatments to the medications. On 7/17/25, resident 7's physician ordered lorazepam (an antianxiety medication) 0.5 mg every four hours as needed for anxiety and restlessness. There was no documentation that the resident's representative was notified of the new medication order, the indication for the medication, the risks versus benefits of that medication, or alternative treatments to that medication. On 12/2/25, resident 7's Abilify was decreased to 12.5 mg at bedtime. There was no documentation that resident 7's representative was informed of the changed medication order, the indication for the change, the risks versus benefits of the medication, or alternative treatments to the medications.	F0552		

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F0552 SS = D	Continued from page 4 On 3/5/26, resident 7's Abilify was decreased to 10 mg at bedtime. There was no documentation that resident 7's representative was informed of the changed medication order, the indication for the change, the risks versus benefits of the medication, or alternative treatments to the medications. 3. Interview on 3/11/26 at 4:36 p.m. with director of nursing (DON) B revealed that written informed consents were not obtained from a resident or resident representative before beginning a psychotropic medication. The residents' medications were reviewed with the resident or their representative upon admitting to the facility and the resident or resident's representative signed that medication list. Neither the medication list nor the residents' baseline care plan addressed the risks versus benefits of psychotropic medications. 4. Interview on 3/12/26 at 1:42 p.m. with licensed practical nurse (LPN) R revealed that when a resident had a new medication order or a change in the dose of a medication, the nurse was to call that resident's representative and notify them of the change. If the resident's representative could not be reached, that nurse would pass that on in her report to the next shift and place the order in a file folder labeled "waiting for family." The next shift would then attempt to call the residents' representative to notify them of the medication order. When LPN R called to notify a resident's representative of a new medication, she reviewed the reason the medication was being ordered, the risks of the medication, and answered any questions the resident's representative had. Once the resident's representative was notified of the new medication or change in the dosage of the medication, the notification was to be documented in the resident's progress notes under the "communication with family" category. 5. Interview on 3/12/26 at 1:50 p.m. with Minimum Data Set (MDS) registered nurse (RN) E revealed that the nurses were to notify the resident's representative before a psychotropic medication was started. They did not have a consent form for psychotropic medications that contained the medications' risks versus benefits review with the resident's representative. She was not aware that the regulation required the risks versus benefits and alternative treatments to the medication	F0552		

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F0552 SS = D	Continued from page 5 was to be reviewed with the resident or the resident's representative before a psychotropic medication was started. She expected the staff to document in the resident's progress notes that they had notified the resident's representative when a new medication was started or if there was a change in that medication's dose. She explained that resident 7's representative was difficult to reach, and he did not call the provider back after he was called. She expected the staff to document any attempts made to contact a resident's representative in that resident's progress notes. 6. Interview on 3/12/26 at 1:57 p.m. with DON B revealed that a resident or the resident's representative was to be notified if there was a new medication ordered, a dose of a current medication was changed, or if a medication was discontinued and that notification was to be documented in a progress note in that resident's EMR. She expected the nurses to discuss the risk versus benefits as well as the reason the psychotropic medication was started, or why the dose of the medication was changed with the resident or the resident's representative. She stated they did not have a professional reference for the nurses to use when they reviewed the risks versus benefits of the psychotropic medications and alternative treatments. She mentioned that resident 7's family was difficult to reach at times, but she expected the nurses to document their attempts to reach resident 7's representative in a progress note. She was not aware that the regulation required the risks versus benefits and alternative treatments to be reviewed with the resident or the resident's representative before a psychotropic medication was started. 7. Further interview on 3/12/26 at 2:35 p.m. and 2:50 p.m. with DON B revealed that resident 2's POA was not too involved with her care. They left voicemails on his contact phone number because he rarely answered their	F0552		

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F0552 SS = D	Continued from page 6 calls. She confirmed that she could not find documentation showing that informed consent was obtained from resident 2's POA regarding the aripiprazole. There currently was no system in place to ensure staff were educating and obtaining informed consents from the residents and their representatives about changes in the residents' care. 8. Review of the provider's 10/5/22 Use of Psychotropic Medication policy revealed that the resident's attending physician was responsible for managing the resident's medications. The policy included that the "residents and/ or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions."	F0552		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days	F0640	The MDS nurses corrected and/or submitted discharge tracking MDSs for residents 33, 43, and 92. Review of RAI Manual on MDS transmission was completed with MDS nurses on 3/30/26. The current process was reviewed and a new system utilizing Point Click Care (PCC) was initiated. MDS Coordinators will utilize the "Scheduled" tab in PCC under MDS weekly, as well as the Medicaid Portal, to ensure MDS are being submitted in a timely manner. MDS Coordinator, or designee, will review all MDS transmissions weekly for accuracy and timely submission due that week until QAPI Committee determines otherwise. Results will be reported monthly to the QAPI committee and quarterly to the Quality Assurance Committee with the Medical Director.	04/10/2026

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F0640 SS = D	Continued from page 7 after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review revealed the provider failed to ensure staff electronically submitted Minimum Data Set Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessments to the Center for Medicare and Medicaid Services (CMS) within the required 14 day time frame from the residents' discharge for three of three sampled discharged residents (33, 43, and 92). Findings include: 1. Review of resident 33's electronic medical record (EMR) revealed he was admitted to the facility on 6/1/21. He was discharged to the hospital on 11/4/25. His 11/4/25 discharge tracking MDS assessment was not transmitted to CMS.	F0640		

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F0640 SS = D	Continued from page 8 2. Review of resident 43's EMR revealed she was admitted to the facility on 9/25/25. She was discharged on 11/25/25 to her daughters' home. Resident 43's 11/25/25 discharge tracking MDS assessment was not transmitted to CMS. 3. Review of resident 92's EMR revealed she was admitted to the facility on 11/3/25. She passed away on 12/5/26 while at the hospital. Resident 92's 12/5/25 discharge tracking MDS assessment was not transmitted to CMS. 4. An interview and record review on 3/11/26 at 2:52 p.m., with Minimum Data Set (MDS) registered nurse (RN) F, regarding the tracking and transmission of discharge MDS assessments revealed she was responsible for ensuring the MDS assessments were transmitted to CMS within the required time frames. She reported she used the RAI Manual Version 1.20.1 October 2025 for reference, and acknowledged she was aware of the required MDS transmission timelines, including completion of a resident's discharge MDS within fourteen days of the date of discharge and transmission to CMS within fourteen days of the MDS completion date. After reviewing the discharge MDS assessments for residents 33, 43, and 92, she confirmed that those discharge tracking MDS assessments were not transmitted to CMS. She reported she was using an electronic MDS system along with a paper "cheat sheet" tracking form to monitor MDS transmissions. Resident 43's 1/4/26 discharge was not added to her paper tracking form. Upon further review of the discharge MDS assessments, MDS RN F identified that resident 33's discharge MDS assessment was not completed and therefore not transmitted to CMS. She acknowledged the assessment should have been completed within seven days of resident 33's discharge from the facility. Additionally, MDS RN F reported that Resident 92 had passed away at the hospital; however, the discharge MDS assessment incorrectly indicated the resident had passed away in the facility. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 revealed "Assessment Transmission ... Tracking Information Transmission: For Entry and Death in Facility tracking records, information must be transmitted within 14 days of the Event Date (A1600 + 14 days for Entry records and A2000 + 14 days for Death in Facility records)."	F0640		
F0657	Care Plan Timing and Revision	F0657		

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F0657 SS = D	Continued from page 9 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (2) with dementia and episodes of hallucinations, behaviors, and agitation, had person-centered interventions included in the resident's plan of care for the staff to implement to assist the resident during those episodes to meet her dementia care needs. Findings include: 1. Observation and interview on 3/11/26 at 9:44 a.m. in the Morning Dove Lounge revealed that resident 2 was sitting in a recliner. She had her left leg pulled up	F0657	Comprehensive Care Plans policy was reviewed and revised by the IDCP team. Resident 2's care plan was reviewed with nursing staff, including CNAs, and updated with current behavioral goals and interventions. Care plans for all residents with behavioral dementia and hallucinations were reviewed by IDCP team with CNA assistance to ensure individualized interventions and goals were up to date to reflect their needs. Education was provided to IDCP team on updating care planning interventions specifically related to behavioral symptoms that have been found to be effective. Social Services, or designee, will audit care plans on current and new residents with diagnosis of dementia with behaviors for accuracy and individualized interventions weekly for 4 weeks, then monthly until QAPI Committee determines otherwise. Results will be reported monthly to the QAPI committee and quarterly to the Quality Assurance Committee with the Medical Director.	04/10/2026

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F0657 SS = D	Continued from page 10 towards her torso, and she appeared to be trying to adjust her gripper sock or the cuff of her pants. Her walker was in front of her. She was not wearing shoes. When asked how she was doing that day, she mumbled about there being a "bum" on or near her left foot. She was not easily understood. She put her left foot back down on the floor, reached forward, and continued to point and readjust her pant leg while talking about "the bum." 2. Interview on 3/12/26 at 12:29 p.m. with certified nurse aide (CNA) K revealed that resident 2 often wandered throughout the facility without shoes on. They helped resident 2 put gripper socks on in the mornings in case the resident decided to take her shoes off. She confirmed that resident 2 often experienced hallucinations about a lost dog or children. They would not try to bring her out of the hallucinations, instead they would validate her experience by acknowledging the dog or children that were not actually there. This helped the resident remain calm instead of worrying about the lost dog or children. 3. Review of resident 2's electronic medical record (EMR) revealed that her diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), unspecified psychosis not due to a substance or known physiological condition, unspecified hallucinations, delusional disorder (false beliefs and distorted views of reality), dementia (a group of symptoms affecting memory, thinking, and social abilities), depression, and anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). Her care plan included a "Background" focus area that was last updated on 10/3/24 that read, "[Resident 2] has been living at [a local assisted living center] since 11/10/23. In recent weeks became very paranoid / untrusting / seeing / talking to someone not there." The associated care plan goals, last revised on 9/5/25, included, "Will adjust to LTC [long term care] stay and relying on others for cares as needed through next review... Will show interest in planning / organizing her daily routine through [next] review... Enjoy time with family as they visit through next review."	F0657		

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F0657 SS = D	Continued from page 11 The associated care plan interventions, all initiated on 7/18/24 and not revised since, included, "Give cues, reminders, supervision and hands on direction... Keep lines of communication open with Resident / Family / Staff... Provide opportunity to plan / organize her day of offering activities which will provide opportunity to enhance her optimum level of functioning / well being in LTC." Her care plan did not include any focus areas, goals, or interventions related to her usual hallucinations or the staff's approaches to address her hallucinations. There were several progress notes that documented her hallucinations, including a 2/26/26 behavior note that read, "Resident actively hallucinating this shift. Seeing children and becoming agitated when staff doesn't acknowledge them. Loudly saying, 'open your eyes boys and girls, your parents are here.'..." Her 2/23/26 quarterly Minimum Data Set (MDS) assessment included that she experienced hallucinations and delusions. Her Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated that she had severe cognitive impairment. Her 6/16/25 annual MDS assessment Care Area Assessment worksheet included that she had "Long-standing mental health problem associated with the behavioral disturbances, such as schizophrenia, bipolar disorder, depression, anxiety disorder, post-traumatic stress disorder," "Delusions," and "Hallucinations." The care plan considerations associated with those conditions read, "Delusions and hallucinations have been observed. [Diagnoses] of anxiety and depression and on [medications] for [the] same. Does follow with [local psychiatric provider.]" 4. Interview on 3/12/26 at 3:11 p.m. with social services director W revealed that she and the other social worker were responsible for the behavior portion of a resident's care plan. However, they reviewed and revised each resident's care plan as an interdisciplinary team. If a resident had hallucinations, she said, "We might put a history of hallucinations."	F0657		

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F0657 SS = D	Continued from page 12 She confirmed that resident 2's care plan did not include interventions for the staff to consider when the resident was experiencing her hallucinations. Resident 2's care plan did include, however, that she had a history of paranoia and "seeing things that are not there." She expected staff to utilize the resident's care plan, the electronic medical record, and for other experienced staff to know how to take care of each resident. 5. Review of the provider's 4/2019 Comprehensive Care Plans policy revealed that the policy statement read, "It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident...that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment." The policy included utilizing the comprehensive MDS assessment and all triggered Care Area Assessments when developing the comprehensive care plan. One of the topics described to be included in each comprehensive care plan included, "The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the provider failed to ensure the staff followed nursing professional standards related to following physician orders regarding blood glucose monitoring and physician notification for one of one sampled resident (3) who had low blood sugar levels, and oxygen saturation (percentage of oxygen in the blood) monitoring for one of one sampled resident (32) with physician's orders to keep her oxygen saturation levels above 90 percent.	F0658	In review of current diabetic residents with insulin/blood sugar monitoring orders all have parameters in place for notifying physician/practitioner as needed. LPN S was educated on the proper physician notification policy/procedure on 3/12/26 by RN staff education director. All licensed staff will be re-educated with policy and diabetic protocol review by 4/10/26. PRN staff or staff on leave will be educated prior to the start of their next shift. Education will include following diabetic protocol when blood glucose levels fall above or below MD written parameters and how to enter orders into Point Click Care. All current residents with oxygen orders were reviewed for accuracy. Batch orders were updated for all new Oxygen orders going forward to automatically require oxygen saturation monitoring be documented in the TAR. Care plans were reviewed for accuracy. All licensed staff will be	04/10/2026

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F0658 SS = D	Continued from page 13 Findings include: 1. Interview on 3/10/26 at 3:00 p.m. with resident 3 revealed he received insulin. He had a history of low blood sugar levels in the mornings. He mentioned that he did not feel any different when his blood sugar level was low. The staff usually gave him a glass of juice if his blood sugar was low. Sometimes, his blood sugar level got as low as 50 to 57 (milligrams per deciliter, mg/dL) in the mornings. 2. Review of resident 3's electronic medical record (EMR) revealed he had a diagnosis of Type 2 Diabetes Mellitus (a condition involving disruptions in how the body regulates blood sugar) with diabetic chronic kidney disease. He had a current 3/2/26 physician's order for "Accuchecks [a brand of blood glucose monitoring systems] BID [twice per day] [notify] Dr. [doctor] if BS [blood sugars] [are] less than 70, or greater than 400 two times a day." His previous order for blood sugar level checks read, "Accuchecks BID Dr. if BS less than 70, or greater than 400 every morning and at bedtime." That order was active from 9/2/25 through 3/2/26. On 2/8/26 his blood sugar was 55 mg/ dL, on 2/7/26 his blood sugar was 59 mg/dL, and on 10/16/25 his blood sugar was 65 mg/dL. There was no documentation that his physician was notified of those low blood sugar levels. 3. Interview on 3/12/26 at 4:08 p.m. with LPN T revealed that if a resident's blood sugar fell below or above specified parameters, the resident's physician was to be notified. 4. Interview and record review on 3/12/26 at 4:10 p.m. with staff education director/infection preventionist U revealed that she confirmed there were no physician notifications for the above-listed dates. She said that she talked to the nurse that was on shift those days, and that nurse informed her that resident 3 also experienced low blood sugars on 2/2/26, 2/3/26, and 2/4/26. She notified the physician of those low blood sugars, and the physician did not change any interventions. The nurse told staff education director/infection preventionist U that she did not notify resident 3's physician on 2/7/26 and 2/8/26 because she did not think he would change any of the resident's interventions or provide further direction to address resident 3's low blood sugar levels.	F0658	re-educated on oxygen orders and saturation monitoring including how to enter batch orders to include prompts to check and document oxygen saturations and liter flow by 4/10/26. PRN staff or staff on leave will be educated prior to the start of their next shift. DON or designee will audit all diabetic residents with physician ordered glucose monitoring for physician notification as indicated and audit all residents with physician ordered oxygen for documentation of oxygen saturation and liter flow weekly for 4 weeks, then monthly until the QAPI team determines otherwise, and quarterly to the QA &A committee with the medical director.	

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F0658 SS = D	Continued from page 14 5. Interview on 3/12/26 at 4:11 p.m. with DON B revealed that she expected the staff to notify the residents' physician each time the blood sugars were out of the specified ranges according to the physician's orders. 6. Review of the provider's 7/28/23 Glucometer Standards (Assure Pro) policy revealed that "critical high and low tests of residents will be managed according to their physician's orders." The instructions read, "Check each resident's [parameter] and report per physician's order." 7. Review of the provider's 5/24/23 Physician Notification Policy revealed that "it is the policy of this facility to timely notify the physician...of changes in resident condition." The policy defined "promptly" as "results shall be relayed with little or no delay to the ordering physician..." The policy explanation included, "The facility must promptly notify the attending physician... of changes in resident condition that falls outside the 'normal' range for that specific resident, in accordance with facility policies and procedures. Delayed notification may contribute to delays in changing the course of treatment or care plan." 8. Observation on 3/11/26 at 9:03 a.m. in resident 32's room revealed that there was an oxygen concentrator machine (a device that filters room air into purified oxygen) at the foot of her bed. The machine was turned on, but no one was in the room using it. 9. Review of resident 32's EMR revealed that she had a 6/3/25 physician's order for "O2 [oxygen] at 2L [liters] via nasal cannula [flexible tubing with prongs that delivers oxygen through the nose] to keep sats [saturation; percentage of oxygen in the blood] above 90% [percent] every morning and at bedtime related to ACUTE RESPIRATORY FAILURE WITH HYPOXIA [low oxygen levels in the body]." Resident 32's medication administration record, treatment administration record and record of vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) documentation indicated that her blood oxygen saturation was last documented as measured on 3/1/26.	F0658		

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F0658 SS = D	Continued from page 15 From 1/1/26 to 3/11/26, her blood oxygen saturation levels were documented as measured a total of six times. Her care plan included a 4/29/25 intervention that read, "OXYGEN SETTINGS: O2 via nasal [cannula] @ [at] 2L at night and when sleeping." 10. Interview on 3/11/26 at 3:39 p.m. with registered nurse (RN) Q revealed that a resident's blood oxygen saturation was to be monitored more frequently if the oxygen flow rate was adjusted. If the resident asked for oxygen, she expected the resident's blood oxygen saturation level to be measured before administering oxygen and rechecked an hour later. 11. Interview on 3/11/26 at 3:42 p.m. with LPN S revealed that resident 32 usually received oxygen with the use of the oxygen concentrator at night. 12. Interview on 3/11/26 at 3:51 p.m. with RN Q revealed that she reviewed resident 32's EMR and confirmed that the resident's oxygen order in the EMR system did not include blood oxygen saturation checks. 13. Interview on 3/11/26 at 4:01 p.m. with DON B revealed that she expected the staff to monitor and measure a resident's blood oxygen saturation levels according to the physician's orders. She expected the staff to measure resident 32's levels before she went to bed each night. She confirmed staff was not doing that. 14. Review of the provider's 12/10/24 Oxygen Administration policy revealed that "the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as... Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered."	F0658		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F0686	Pressure Injury Prevention and Management Policy was reviewed and revised by DON, Administrator and Medical director and interdisciplinary team. All care plans were reviewed to ensure individualized pressure ulcer prevention interventions are in place as deemed appropriate for each resident.	04/10/2026

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F0686 SS = G	Continued from page 16 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure pressure injury prevention interventions were identified and implemented for one of one sampled resident (70) who developed a deep tissue injury (DTI) (a pressure ulcer/ injury with purple or maroon discolored skin and underlying soft tissue damage, caused by intense, prolonged pressure) on her right heel. Findings include: 1. Observation and interview on 3/10/26 at 2:35 p.m. with resident 70 while she was in her room watching television, revealed that her bed was located next to the window. She had hard surface protective boots on both her lower legs and feet. There were Velcro straps that were wrapped around her lower legs, holding those boots in place. She stated that she had multiple sclerosis (a condition where the immune system attacks the nervous system, causing damage and scar tissue) and that she had a "left heel pressure injury" that developed before she was admitted to this facility from another long-term care facility. After she was admitted to this facility, she received a protective boot for her left foot and heel. Resident 70 stated she then developed a "pressure injury to my right heel." She reported that "24/7" (twenty-four hours a day, seven days a week) continuous boot use on her left foot and the involuntary movement of her left leg while in bed caused friction between her right and left heels, which she believed contributed to the development of the pressure injury on her right heel. The resident stated that the left heel injury had healed.	F0686	Directed staff in-service for all nursing department staff regarding pressure injury prevention and management to be completed by 4/10/26. PRN staff or staff on leave will be educated prior to the start of their next shift. The in-service will include education regarding the importance of pressure injury prevention, disease processes, risks for development of pressure injuries, risk assessments, skin assessments, wound assessments, prevention strategies, treatment strategies, and updating care plans with individualized goals and approaches to include resident involvement (interview) if applicable. All nurse managers including RCCs/wound care nurses participated in SDAHO webinar regarding minimizing pressure injury risk on 4/2/26. Skin PIP will also continue to meet monthly to review pressure injury prevention strategies on all residents in the facility. RCC or designee will audit the accuracy of Braden risk assessments, to include individualized resident specific care plan updates per facility policy. Audits will be conducted on all new admissions, readmissions, significant change residents and current residents with pressure injuries for accuracy weekly for 4 weeks, then monthly until the QAPI committee determines otherwise, and quarterly to the QA & A committee with the medical director.	

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F0686 SS = G	Continued from page 17 2. Observation and interview on 3/12/26 at 1:31 p.m. with resident 70 revealed resident 70 was in her room, sitting in her wheelchair, sorting through clothes, with tennis shoes on both of her feet. Resident 70 stated that she had attended a wound care appointment earlier that day, and that the wound care staff informed her that her left heel was "healed." Her right heel would "only need iodine on the scab until it falls off," and no dressing was required for her right heel at this time. Resident 70 stated she was instructed to continue to wear both protective boots "when in bed and occasionally during the day." Resident 70 stated that when she was in bed, she was able to adjust her upper body using the grab bar (bar attached to the bed) located on the left side of her bed and by holding onto the windowsill on the right side. She said that she could not independently reposition her lower body and that her legs occasionally had muscle spasms. She was able to feel the pressure injury on her right heel and stated that it "hurt". 3. Review of resident 70's electronic medical record (EMR) revealed she was admitted to the facility on 1/14/26. Her Brief Interview of Mental Status (BIMS) assessment score was a 15, which indicated her cognition was intact. Her diagnoses included: Multiple Sclerosis (MS), paraplegia (the loss of motor and sensory function in the lower body), muscle wasting and atrophy (wasting of muscle tissue, leading to reduced size, weakness, and limited mobility) of the right and left thighs and lower legs, and muscle weakness. Her 1/21/26, 2/4/26, and 2/11/26 Braden Scale (a tool used to assess the risk of developing pressure ulcers) assessment scores were all 19, which indicated she was not at risk for the development of a pressure injury. There were no further documented Braden Scale assessments after 2/11/26. Resident 70's "Wound-Weekly Observation Tool" assessments revealed that on 2/5/26, she had developed a facility "acquired", "Type [of wound]:" "pressure" to her right heel. The assessment identified the "Pressure Ulcer Stage" as a "suspected DTI (SDTI)." The wound measurements were 22 millimeters (mm) by 32 mm, with no depth recorded. The peri-wound tissue (the skin surrounding a wound edge) was described as "Pink, dry,	F0686		

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F0686 SS = G	Continued from page 18 intact". The treatment was "Foam dressing weekly et [and] Multipodus boot [a specialized, rigid orthopedic device designed to prevent and correct pressure ulcers [injury] in bedridden or immobile patients]." On 2/9/26 the measurements of her SDTI were 20 mm x 30, with no depth recorded. The treatment was "Foam dressing weekly et Multi-podus boots. Resident 70's 3/9/26 right heel SDTI measurements were 15 mm x 25 mm, with no depth recorded. The SDTI was described as "Pink, dry, intact". Treatment was "Foam dressing et Multi-podus boots to BLE [bilateral lower extremities]." The wound was described as "Wound is [the] same in size as [the] previous week's measurement. Scab is starting to lift up around the edges. Will continue ordered tx [treatment] and to monitor." Resident 70's 1/19/26 Dietitian Nutritional Assessment, completed by Registered Dietitian Nutritionist (RDN) X, indicated she had a pressure injury to her left heel and "resident reports her legs are 'too weak' to return [to her home]. Resident does have history of MS", and "Resident does have [a] history of MS and endorses lower extremity weakness. Will communicate [the] addition of 1 oz [ounce] of Prosource daily to CDM [certified dietary manager]. Her 2/10/26 Dietitian Nutritional Assessment indicated "writer [RDN] was also notified of SDTI to [the] right heel that was identified by resident [70's] nurse." 4. An interview on 3/12/26 at 1:45 p.m. with certified nursing assistant (CNA) K regarding resident 70's right heel SDTI injuries revealed that when she arrived at work in the morning, resident 70 typically had her protective boots on her feet. CNA K stated that she would then remove the boots and place shoes on resident 70 so the resident was able to use a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) to go into the bathroom. Afterward, resident 70 was assisted into a wheelchair using the sit-to-stand lift, and the protective boots were then placed back on her feet. CNA K reported that resident 70 was able to use her call light. She stated that the staff repositioned residents and attempted to offload resident 70's heels; however, resident 70 would sometimes allow the staff to offload her heels, and at other times she refused. Resident 70's left leg would sometimes "twitch" when a	F0686		

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F0686 SS = G	Continued from page 19 staff member was applying her protective boots. 5. An interview on 3/12/26 at 2:00 p.m. with registered nurse (RN)/resident care coordinator (RCC) H regarding resident 70's heel pressure injuries revealed that resident 70 was admitted to the facility with a pressure injury to the left heel and was referred to wound care, who ordered a boot for the resident's left heel. Resident 70 wore a foam boot on the left heel until the "Podus" boot (an orthopedic device with a rigid outer frame and a soft, often removable, liner that keeps the ankle in a neutral position while elevating the heel to eliminate pressure) arrived. RN/RCC H was unable to recall when the Podus boot arrived. RN/RCC H reported that the pressure injury on resident 70's right heel was identified as a "facility-acquired SDTI", which she attributed to the resident sitting in her wheelchair, wearing shoes, and having a diagnosis of MS. At that time, resident 70 was wearing a shoe on the right foot. RN/RCC H stated that a Podus boot for the right foot was subsequently ordered. Before that, interventions included the use of skin preparation and a foam dressing. RN/RCC H reported that resident 70 could reposition and move her legs while she was in her bed and that her legs were floated (the process of elevating the legs off the bed to remove contact, ensuring they do not bear weight) when she was in her bed to reduce pressure to her heels. 6. Review of the provider's revised 6/1/22 Pressure Injury Prevention and Management policy revealed "Licensed nurses will conduct a pressure injury risk assessment, using the Braden Scale, on all residents upon admission/re-admission within 24 hrs [hours], weekly x [times] four weeks, after a change of condition, after any newly identified pressure injury, and quarterly." "Review and revise Care Plan with needed interventions ..." "Interventions will be based on specific factors identified in the risk assessment, skin assessment, and any pressure injury assessment (e.g., moisture management, impaired mobility, nutritional deficit, staging, wound characteristics)." "Interventions will be documented in the care plan and communicated to all relevant staff." "In the absence of prevention orders, the licensed nurse will utilize nursing judgement in accordance with pressure injury prevention guidelines to provide care, and will notify [the residents'] physician to obtain orders as needed."	F0686		

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F0686 SS = G	Continued from page 20 7. Review of the provider's 2025 Pressure Injury Prevention Guidelines revealed "Use positioning devices or folded linens to keep body surfaces from rubbing against one another." "Consider use of prophylactic dressings for prevention of sacral and heel pressure injuries." "Ensure that heels are floated off the surface of the bed, using pillows or devices that elevate and offload the heel in such a way as to distribute the weight of the leg along the calf without placing pressure on the Achilles tendon [a tendon connecting calf muscles to the heel bone]." 8. Interview, record review, and policy review, on 3/12/26 at 2:09 p.m. with director of nursing (DON) B revealed resident 70 was admitted to the facility with a "SDTI" on her left heel. Resident 70 had developed a facility-acquired SDTI on her right heel "shortly" after she was admitted. She stated the Braden Scale assessments were completed when a resident was admitted to the facility and then weekly for the next three weeks, if they had a pressure injury or a significant change in condition, each quarter, when they returned from hospitalization, and when a resident developed a new pressure injury. After DON B reviewed the providers Pressure Injury Prevention and Management policy and the Pressure Injury Prevention Guidelines policy she stated she expected a resident's Braden Scale assessment to be completed with every new pressure injury, and weekly until the pressure injury was healed. After reviewing resident 70's 2/11/26 Braden Scale assessment, she agreed that question 1's answer to "Ability to respond meaningfully to pressure-related discomfort" was incorrect and should have been coded "at least slightly limited impairment". She stated, "Even her diagnoses would have indicated that." She indicated question 8 "Friction & [and] ..." was coded incorrectly and should have been coded as "Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction." She stated that resident 70 was unable to move independently in bed, and "in hindsight, maybe [we] should have ordered two [Podus boots] to begin with." She confirmed resident 70's left side Podus boot could have rubbed her right heel if resident	F0686		

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F0686 SS = G	Continued from page 21 70's leg spasmed when she was in bed. After reviewing resident 70's care plan, DON B confirmed that resident 70's care plan should have included the necessary care she required, and her care plan had not included her not being able to reposition her legs, the use of Podus boots, or that her heels were floated. She stated that pressure injuries are typically included in the residents' care plans. She indicated RN/ RCC H was responsible for updating resident 70's care plan, or that RN/RCC H should have asked MDS RN F for help in updating it. DON B stated, "We should have been repositioning [resident 70]", and "we do have pressure-reducing mattresses, or pillows."	F0686		04/10/2026
F0803 SS = E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by:	F0803	On 3/12/26 went through all menu items and provided missing recipes. 3/17/26 a conversion chart for scoop sizes provided, explained to cooks 1-1 and posted for reference. On 3/27/26 reached out to Stella (software program used for menus, recipes, order taking, exc.) to have NAS diet added to menu plan. On 3/31/26 all serving sizes had been added to cook's menus and RDN reviewed serving sizes and these were put in recipe binders. Also on 3/31/26 confirmed Stella will add NAS diet to menu plan extensions. Once they complete, Culinary Director will add portion sizes to spreadsheet as portion sizes are not included in the report ran from Stella, will have RDN review menu plans with portion sizes for compliance, make any changes suggested if needed, and have RDN sign off on all menus. Culinary Director will work with nursing to remove any unused diet orders from Point Click Care system and providing education to additional support staff on diets allowed at facility to address utilizing Heart Healthy vs NAS diet in the EMR. On 4/1/26 collaborated with nursing and updated current resident diets from Heart Healthy to facility offered NAS diet. Began staff meetings on 3/30/26 providing education over proper serving and scoop sizes and NAS diet menu plan and working with Stella software program on correction. Education to all culinary staff will be completed by 4/10/26. PRN staff or staff on leave will be educated prior to the start of their next	

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F0803 SS = E	Continued from page 22 Based on observation, interview, and record review, the provider failed to ensure the menu serving sizes and therapeutic diet menus were created and followed regarding: *One of one chef (P) failed to follow the menu serving sizes for each resident who was offered food at the facility for one of two observed meal services. *Nine of nine sampled residents (1, 7, 15, 17, 42, 48, 53, 75, and 90) who were prescribed a "NAS" (no added salt) diet, and eighteen of eighteen residents (9, 20, 21, 23, 27, 32, 33, 40, 41, 46, 50, 57, 63, 68, 71, 78, 79, and 87) who were prescribed a "Heart healthy" diet, and did not have their therapeutic diet created or followed. Findings include: 1. Observation on 3/12/26 at 8:41 a.m. in the kitchen of chef P revealed he was serving breakfast from a steam table. He served ham and cheese egg scramble with a green-handled #12 scoop, and breakfast potatoes with a pair of tongs. There was a meal ticket printer that printed the residents' meal choices. Those meal tickets included the menu item, but not the serving sizes. 2. Review of the provider's menu and recipe binder at that time revealed that the serving size for the ham and cheese egg scramble was four ounces. The binder did not include a recipe or serving size for the breakfast potatoes. 3. Interview on 3/12/26 at 8:51 a.m. with chef P revealed that the facility did not have a chart noting scoop sizes. He said that they "just have to know the amounts." He said he believed the green #12 scoop that he was using for the ham and cheese egg scramble was about four ounces. 4. Interview on 3/12/26 at 8:54 a.m. with culinary managers C and D revealed that they confirmed there was no conversion chart referencing scoop sizes. The green #12 scoop was three ounces, not four ounces.	F0803	shift. The Director of Culinary services or designee will conduct audits on proper portion sizes will be conducted x3 per day for 2 weeks, twice daily for 2 weeks, daily for 2 weeks then weekly thereafter until QAPI determines sustained compliance. Audits will begin on 4/10/26. The Director of Culinary Services will report monthly to QAPI committee and quarterly QA&A meeting with medical director.	

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F0803 SS = E	Continued from page 23 At that time, the survey team requested a copy of the menu with serving sizes for each meal during the survey week. Culinary manager D said they did not have menus with serving sizes listed because the serving size information was listed in each recipe within the menu and recipe binder. Record review and interview at that time with culinary managers C and D revealed that there were no recipes included in that binder for the breakfast potatoes, baked beans (on the menu for lunch on 3/12/26), and minestrone soup (on the menu for lunch on 3/12/26). Culinary managers C and D were not aware that those recipes were not included in the menu and recipe binder. Culinary manager D said the staff use iPads to order the residents' meals within a software program that, instead of listing serving sizes, tells the staff if the residents exceeded their allotted nutritional count for that meal. They confirmed that residents on therapeutic diets, such as a diabetic diet, heart healthy diet, or low sodium diet, all received the same menu as the regular diet. 5. Continued interview on 3/12/26 at 9:16 a.m. with culinary managers C and D revealed that it was standard for the staff to use the green scoop when serving the ham and cheese egg scramble. Culinary manager D confirmed the staff should have used a four-ounce scoop instead. They confirmed that using tongs to serve the breakfast potatoes was not the best choice as they could not verify the quantity served. 6. Review of the provider's menu for breakfast on 3/12/26 revealed the serving sizes were handwritten on the menu. The menu included four ounces of ham and cheese scramble, three ounces of breakfast potatoes, seven ounces of apple juice, one muffin, three-fourths cup of oatmeal, and seven ounces of milk. 7. Review of the provider's 11/11/25 dietitian-signed menu revealed that the following therapeutic diets were available: pureed, mechanically altered, gluten free,	F0803		

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F0803 SS = E	Continued from page 24 renal, and carbohydrate controlled. There was no menu for a "heart healthy" or "no added sodium" diets. 8. Review of the "diet type report" revealed that residents 1, 7, 15, 17, 42, 48, 53, 75, and 90 were prescribed a "NAS" (No Added Salt) diet, and residents 9, 20, 21, 23, 27, 32, 33, 40, 41, 46, 50, 57, 63, 68, 71, 78, 79, and 87 were prescribed a "Heart healthy" diet.	F0803		
F0812 SS = F	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 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed food safety standards to: *Maintain a clean and sanitary food service environment in one of one main kitchen and one of one activity room kitchenette. *Store raw meat to prevent potential cross-contamination in one of one walk-in cooler.	F0812	On 3/10/26 the juice machine was thoroughly cleaned. On 3/11/26 juice machine and coffee machine cleaning schedules developed, explained 1-1 to working staff and posted on machines. Dishwasher delimed and outside limescale scrubbed to remove build-up. Deliming schedule developed, explained to working staff 11 and posted. On 3/12/26 raw meat rack labeled with correct order of storage from top to bottom and explained to working staff. Freezer floor swept, all debris and build up removed and floor scrubbed. On 3/26/26 missing vent hood located and installed, and coffee machine spouts scrubbed to remove limescale build-up. Sweeping and mopping of freezer floor added to cooks cleaning schedule. On 3/27/26 updated food storage policy to include order of raw meat storage from top to bottom and sink in dishwashing area thoroughly cleaned. Began staff meetings on 3/30/26 providing education on deliming of dishwasher and schedule, cleaning of coffee and juice machines properly and schedules, keeping sink areas clean, sweeping/mopping of freezer floor and schedule, and raw meat rack proper order of storage. Managers will verify cleaning tasks completed as scheduled when staff checking out at end of shift. Education will be provided to all culinary staff to be completed by 4/10/26. PRN staff or staff on leave will be educated prior to the start of their next shift. Audits on sink area and raw meat rack storage will be done daily for 4 weeks then weekly thereafter. Audits for deliming the dishwashing machine, cleaning coffee and juice machines and sweeping and mopping freezer floors will be done weekly for 4 weeks then monthly thereafter. All audits will begin	04/10/2026

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F0812 SS = F	Continued from page 25 *Label and date bulk food ingredients in one of one activity room kitchenette according to the provider's policy. *Ensure one of one activity room dishwasher used for special events reached the temperature required for sanitizing residents' drinkware and dishes. *Ensure hand hygiene (washing hands or using hand sanitizer) was performed after direct contact with soiled surfaces and resident equipment by certified nurse aide (CNA) (M) before the CNA poured water into glasses for three of three sampled residents (1, 19, and 67) during one of two observed meal services. Findings include: 1. Observation on 3/10/26 at 8:35 a.m. in the dining room revealed the popcorn machine was sitting in the bar area. The machine had leftover popcorn kernels in the bottom of the basin and the kettle had a black burnt-on oily residue. Observation during the initial kitchen tour on 3/10/26 from 8:41 a.m. to 9:16 a.m. revealed there was limescale buildup in the dishwasher. There was a crusty white residue that had built up on the wash arms, inside the doors, and within the door seams of the dishwasher. The handwashing sink in the dishroom appeared stained and had food debris in the basin and in the drain. The walk-in freezer floor was made of stainless steel. Some areas of the floor had turned black with a buildup of an unknown residue. There was a collection of empty food packaging, food crumbs, and dirt on the floor. There was an opened bag of diced onions in the walk-in cooler that did not have an "open date" on it to indicate when the bag was opened. There was a metal rack of raw meat in the walk-in cooler. There were two 10-pound tubes of ground beef on the top shelf, four packages of beef stew meat on the middle shelf, and at least three cases of raw pork loin chops on the bottom shelf.	F0812	on 4/10/26 and be conducted by the Director of Culinary Services or designee and continue until QAPI determines sustained compliance. Director of Culinary Services will report monthly to QAPI committee. Hand Hygiene policy was reviewed by Infection Control RN. Education provided to CNA M with regards to hand hygiene on 3/27/2026 by Infection Control RN. Hand hygiene will be reviewed with nursing staff at the 4/10/2026 mandatory in-service by the Infection Control RN. All culinary staff were educated during their staff meetings and was completed by 4/10/26 PRN staff or staff on leave will be educated prior to the start of their next shift. Infection Control RN, or designee, will audit for hand hygiene one meal a day (rotating meals) times 2 weeks then four meals a week for 2 weeks, then 8 meals monthly for compliance, until QAPI Committee determines otherwise. Results will be reported monthly to the QAPI committee and quarterly to the Quality Assurance Committee with the Medical Director. Label date bulk food in activities kitchenette and storage of utensils in bulk food items. If bulk items are kept in the kitchenette proper labeling and dating will occur. Preference is to have these items not kept in activities kitchenette. Activity staff will be educated regarding proper dating and storage of bulk food items. Education will occur before 04/10/26. Cleanliness of microwave in activity kitchenette. Microwave was deep cleaned on 3/26/26. After each use the microwave will be wiped out and visual inspection of any visual splatters will be taken care of right away. Weekly deep cleaning of the microwave will occur. Activity staff and therapy staff will be educated on proper cleaning of the microwave, which was completed by 3/31/26. Dishwasher in Activities. Dishwasher was unplugged and water turned off on 3/11/26. Dishwasher was removed on 3/30/26. Staff were educated to why we could not have a dishwasher in activity room and were educated on the use of the commercial dishwashers in the Learning Academy and Culinary department at Bethesda Home of Aberdeen kitchen this was	

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F0812 SS = F	Continued from page 26 There was a missing ventilation hood panel above the cooking equipment in the kitchen. There was a beverage station in the dining room. The coffee dispenser had limescale buildup on the spouts. The juice dispenser had an unidentified black substance buildup near the spouts, and the refrigeration vents had a buildup of dust. 2. Observation on 3/10/26 at 12:04 p.m. during lunch service in the main dining room revealed that certified nurse aide (CNA) M was assisting residents into the dining room for the noon meal. She assisted resident 1 to her table in the dining room by pushing her wheelchair. CNA M then knelt down on the dining room floor, unlocked resident 1's wheelchair foot pedals, moved them back, and adjusted resident 1's feet under the table. CNA M then stood and, without performing hand hygiene, picked up resident 1's water glass from the table and poured a glass of water for resident 1. CNA M then picked up resident 67's water glass from the same table and poured him a glass of water. She did not perform hand hygiene after pouring water and exited the dining room. At 12:15 p.m., CNA M returned to the main dining room, pushing resident 19's wheelchair. She assisted resident 19 to her table, touched her right foot pedal lock to adjust it, but resident 19 refused to have her foot pedals adjusted. Then, without performing hand hygiene, she picked up resident 19's water glass from the table and poured a glass of water for her. She did not perform hand hygiene after pouring the water and then exited the dining room. 3. Observation on 3/11/26 at 9:35 a.m. in the activity room kitchenette revealed the microwave had splatters of crusted food on the inside. There were two containers labeled "Sugar" and "Flour" in the cupboards. Neither container was labeled with the date it was filled. There was a spoon sitting within the sugar inside the sugar container. There was a standard household model dishwasher. It was an ASKO brand, and the model number was "D5424." There were several different program options, including Daily	F0812	completed by 3/24/06. Popcorn machine was deep cleaned on 3/12/26. Popcorn machine will be emptied and wiped out after each use. It will be deep cleaned weekly this includes but not limited to the sides and kettle. Education of Activity staff was completed by 3/31/26. Activity director or designee will audit bulk storage of items, cleanliness of microwave and popcorn machine weekly for four weeks and then monthly until QAPI determines compliance and quarterly to the QA & A committee with the medical director.	

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F0812 SS = F	Continued from page 27 wash, Heavy wash, Normal wash, Eco wash, Quick wash, and Rinse & [and] Hold. There were two additional options to choose from, including High temperature and Long dry. There were dishes inside the dishwasher, including coffee cups, a metal mixing bowl, a glass measuring cup, a crockpot ceramic bowl, a glass crockpot lid, and metal eating utensils like forks and spoons. 4. Interview on 3/12/26 at 8:32 a.m. with culinary associate V revealed that she had worked at the facility for about three months. At the end of each shift, they wiped down the outside of the beverage dispensers in the dining room, but she was never instructed to take the machines apart to clean the inside or the dispenser spouts. 5. Observation on 3/12/26 at 8:56 a.m. in the walk-in cooler revealed that the meat shelf had more meat on it than the observation on 3/11/26 during the initial kitchen tour. The top shelf had one 10-pound tube of raw ground beef. The tube of beef was sitting in a reddish puddle of liquid. Directly below that shelf, there was a container of raw turkey roast that was thawing in a pan. Directly below that shelf, there were two additional packages of raw turkey roast. Directly below that shelf, there were packages of raw beef stew meat. The sheet pan that the packages of raw beef stew meat were sitting on had a large puddle of red liquid. Directly below that shelf, there was a case of raw pork loin chops. 6. Interview on 3/12/26 at 8:57 a.m. with chef P revealed that raw poultry was supposed to be on the bottom shelf. Meats like fish were supposed to be at the top. He believed that raw ground meats, like the tube of ground beef in the cooler, could be stored above whole cuts of meat like the pork loin chops. He was not aware that whole cuts of meat were supposed to be stored above ground meats. When asked about cleaning tasks in the kitchen, chef P mentioned that each chef position was assigned cleaning duties daily. There was an additional cleaning checklist that any staff member could choose from to clean. He did not know how often the dishwasher was delimed. He confirmed that the freezer floor was usually swept, but he was not aware if there were any specific chemicals used to scrub or mop the freezer floor.	F0812		

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F0812 SS = F	Continued from page 28 When looking at the cleaning checklists, he confirmed that sweeping or cleaning the freezer was not included on the list. 7. Review of the above-described cleaning checklists revealed that there was one chef cleaning checklist, and one additional cleaning checklist that did not include the frequency expectations of the cleaning tasks. The March 2026 chef cleaning checklist included different tasks to complete Monday through Friday. The freezer, beverage dispensers, and dishwasher were not included on that list. The undated "Cleaning Task" checklist included various cleaning tasks in the kitchen and dining room. The handwashing sink in the dish room was marked as last cleaned on 12/24/25. The dishwasher was marked as last delimed on 1/5/26. The juice and coffee dispensers were marked as last cleaned on 1/6/26. There was a task item listed to "Sweep/Mop walk in fridge" but no tasks listed for cleaning the walk-in freezer. 8. Interview on 3/12/26 at 9:16 a.m. with culinary managers C and D revealed that staff "should be sweeping the floors daily," and mopping the freezer floors monthly. They had a special chemical to mop the freezer floor. They expected the staff to delime the dishwasher every other week. Culinary manager D printed out a new dishwasher deliming schedule and posted it in the dish room for their main commercial dishwasher in the kitchen. Staff delimed the dishwasher the day before, and she commented that she did not know when the dishwasher was last delimed. They were not aware that the cleaning checklist indicated the main commercial dishwasher in the kitchen was last delimed in January 2026. Culinary manager C confirmed that raw poultry should be on the bottom shelf, then ground meats above that, then other meats like the beef stew meat above the ground meats, and fish at the top. Neither culinary manager C nor D were aware that the raw meat in the walk-in	F0812		

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F0812 SS = F	Continued from page 29 cooler was not stored that way. Culinary manager C said that the dishwasher in the activity room kitchenette was the responsibility of the activity department. They did not know if that style of dishwasher was capable of sanitizing dishes. 9. Interview on 3/12/26 at 10:25 a.m. with activities director I revealed that they used the household model dishwasher in the kitchenette to clean residents' coffee cups, happy-hour dishes like glasses, forks, and spoons, and other dishes used when baking treats for residents. The dishes cleaned in that dishwasher did not come into contact with "TCS" foods (time/temperature control for safety). She was not aware if that dishwasher was capable of sanitizing dishes or not. She used the generic brand of dish detergent pods and ran the dishwasher like normal. She did not know if the detergent pods contained chemicals for chemical sanitization. She said the popcorn machine was cleaned each time it was used. "They usually just wipe it all out." The activities staff were responsible for monitoring and maintaining the food ingredients in the activity room kitchenette. She said that they did not usually store the scoop in the bulk ingredient containers. She was not aware that there was a spoon stored in the bulk sugar container. She was not aware of when those bulk ingredients were last filled, or when the containers were last cleaned. She indicated that activities staff and sometimes residents' family members would use the ingredients in the kitchenette to make treats for residents. 10. Review of the provider's dish detergent pods used for the activity room dishwasher revealed it did not contain any chemicals used for chemical sanitization of dishes. 11. Interview on 3/12/26 at 11:08 a.m. with culinary manager D revealed that a high-temperature commercial dishwasher needed to reach at least 180 degrees Fahrenheit to sanitize the dishes. She was not aware if the dishwasher in the activity room kitchenette had the capability to sanitize dishes.	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	**1224 S HIGH ST , ABERDEEN, South Dakota, 57401**

(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 = F	Continued from page 30 12. Review of the owner's manual for the ASKO D5424ADA W/B/S dishwasher revealed that the maximum temperature reached during any of the wash and rinse cycles was 150 degrees Fahrenheit. When using the "High temperature" option, the maximum rinse temperature reached was 160 degrees Fahrenheit, but only for the Heavy wash cycle. The owner's manual did not include information on whether it had the capability to sanitize dishes. 13. Interview on 3/12/26 at 11:18 a.m. with administrator A revealed that the dishwasher in the activity room kitchenette did not reach 180 degrees according to the owner's manual. They did not have a way to monitor the maximum water temperature for that dishwasher. He confirmed items like resident coffee cups and happy hour dishes were cleaned in that dishwasher. The dishes cleaned in that dishwasher did not come into contact with "TCS" foods (time/temperature control for safety). There were no current respiratory or gastrointestinal infectious disease outbreaks in the facility. If the staff could not use that dishwasher for whatever reason, they had two backup dishwashers: one in the main kitchen, and one in the attached child daycare facility. 14. Interview on 3/12/26 at 4:15 p.m. with director of nursing (DON) B revealed that she expected the staff to perform hand hygiene before and after direct resident contact, after direct contact with resident equipment, and before assisting residents with a meal service. DON B acknowledged that hand hygiene should have been performed by CNA M before and after resident contact to help prevent the transmission of infection. 15. Review of the provider's revised 4/3/20 Hand Cleansing policy revealed that the staff should "wash hands before and after resident contact." The policy described hand hygiene "to be the primary means of preventing the transmission of infection." Staff should cleanse their hands "before and after direct resident contact," "before and after eating or handling food," "before and after assisting a resident with meals," and "after handling soiled equipment or utensils." 16. Review of the 2022 Food and Drug Administration (FDA) Food Code found at https://www.fda.gov/food/fda-food-code/food-code-2022 revealed that, "Equipment food-contact surfaces and utensils shall be sanitized." Methods for sanitization	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	**1224 S HIGH ST , ABERDEEN, South Dakota, 57401**

(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 = F	Continued from page 31 include using hot water or chemicals. "After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: ...(B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under §§ [Sections] 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71 [degrees Celsius] [160 degrees Fahrenheit] as measured by an irreversible registering temperature indicator..." Section §4-501.112 includes requirements for "Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures." "The temperature of hot water delivered from a warewasher sanitizing rinse manifold [a central component or pipe fitting that consolidates, distributes, or controls the flow of fluids between multiple sources and destinations] must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning." "The surface temperature must reach at least 71 [degrees Celsius] (160 [degrees Fahrenheit]) as measured by an irreversible registering temperature measuring device to affect sanitization. When the sanitizing rinse temperature exceeds 90 [degrees Celsius] (194 [degrees Fahrenheit]) at the manifold, the water becomes volatile [unstable] and begins to vaporize reducing its ability to convey sufficient heat to utensil surfaces. The lower temperature limits of 74 [degrees Celsius] (165 [degrees Fahrenheit]) for a stationary rack, single temperature machine, and 82 [degrees Celsius] (180 [degrees Fahrenheit]) for other machines are based on the sanitizing rinse contact time required to achieve the 71 [degrees Celsius] (160 [degrees Fahrenheit]) utensil surface temperature." 17. Review of the provider's 11/11/25 Cleaning Dishes in Dish Machine policy revealed that "All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use." 18. Review of the provider's 2021 Deliming Dish Machines policy revealed that the dishwasher was supposed to be delimed twice a month. 19. Review of the owner's manual for the main	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	**1224 S HIGH ST , ABERDEEN, South Dakota, 57401**

(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 = F	Continued from page 32 dishwasher in the kitchen revealed that the manufacturer recommended "your dishwasher should be de-limed regularly; how often will depend on the mineral content of your water." The weekly maintenance checklist included "clean accumulated lime deposits from the wash tank heating element." 20. Review of the provider's 2021 Cleaning Instructions: Coffee, Beverage, Juice, Frozen Yogurt, or Ice Cream Machines policy revealed the coffee machine was to be cleaned weekly by following the manufacturer's instructions, and the juice dispenser should be cleaned by disassembling the parts, running them through the dishwasher, and allowing them to air dry before reassembling. The outside of the machines should be cleaned with cool water and a cleaning solution. The policy indicated to follow the juice dispenser manufacturer's instructions. 21. Review of the provider's 2021 Food Storage policy revealed that "food will be stored in an area that is clean, dry, and free from contaminants. Food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination." The policy indicated that "plastic containers with tightfitting covers or sealable plastic bags must be used for storing...sugar...and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated." In reference to storing meats, the policy included "raw animal foods should be separated from each other and stored on lower shelves (below cooked foods or raw fruits and vegetables) and in drip proof containers." The policy did not indicate in what order the raw animal meats should be stored. 22. Review of the provider's 2021 Cleaning Instructions: Freezers policy revealed that "freezers will be cleaned on a regular basis." Debris should be removed by sweeping. The floors were to be mopped "using floor cleaner for below 0 [degrees Fahrenheit]." 23. Review of the provider's 6/1/24 Popcorn Machine Cleaning Policy revealed that the purpose of the policy was to "ensure that all popcorn machines are cleaned	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	**1224 S HIGH ST , ABERDEEN, South Dakota, 57401**

(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 = F	Continued from page 33 regularly and properly to maintain food safety, equipment performance, and a sanitary environment for customers and staff." The policy indicated that the activities staff were responsible for cleaning and maintaining the popcorn machine. The policy indicated that the popcorn machine must be cleaned after each use by removing unpopped kernels and popcorn debris, wiping the interior surfaces and glass panels, cleaning the kettle exterior, emptying and cleaning the crumb tray, and wiping all interior and exterior surfaces. On a weekly basis, the staff were to "perform a deep cleaning of the kettle and interior surfaces," and "inspect for grease buildup and remove as needed." 24. Review of the provider's infection control program binder revealed no current resident cases of any respiratory or gastrointestinal infections or symptoms.	F0812		

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	**1224 S HIGH ST , ABERDEEN, South Dakota, 57401**

(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 3/10/26. Bethesda Home of Aberdeen 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
Scott Eisenbeisz	CEO/Administrator	04/03/2026

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435073	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home of Aberdeen	1224 S HIGH ST , ABERDEEN, South Dakota, 57401

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 3/10/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethesda Home of Aberdeen was found in compliance.	K0000		

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
Scott Eisenbeisz	CEO/Administrator	04/03/2026

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
	10589	A. BUILDING: _____ B. WING _____	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME OF ABERDEEN	1224 S HIGH ST ABERDEEN, SD 57401

(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 3/10/26 through 3/12/26. Bethesda Home of Aberdeen was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Scott Eisenbeisz

TITLE: CEO/Administrator

(X6) DATE: 04/03/2026