STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING ______ B. WING ______	C 11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH 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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/5/24 through 11/7/24. Bethany Home Sioux Falls was found not in compliance with the following requirements: F582, F623, F625, F657, F803 and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/5/24 through 11/7/24. Areas surveyed included resident neglect and elopement. Bethany Home Sioux Falls was found not in compliance with the following requirements F600.	F 000		
F 582 SS=E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Herrboldt	Administrator	12/17/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and policy review, the provider failed to provide Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) for one of three (247) sampled residents. This citation is considered past non-compliance based	F 582	Past noncompliance: no plan of correction required.	

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F 582	Continued From page 2	F 582		

on review of the corrective actions the provider implemented following the incident. Findings include:

Review of provider's documentation regarding advanced beneficiary notices (ABN) revealed on 10/11/24, the provider identified previous social worker (SW) O had not been completing SNF ABNs or NOMNCs for residents who received Medicare Part A skilled services.
*Administrator A interviewed (SW) O and SW P on 10/16/24.
-SW O had reported he was not trained upon his hiring on how to complete the ABNs by SW P.
-SW P had reported she had trained SW O upon his hiring on how to complete the ABNs.

Record review on 11/6/24 of the provider's SNF Beneficiary Notification Review Form CMS-20052 revealed:
*Three randomly selected residents were given to the provider for review of SNF ABN.
*Resident 247's Medicare A skilled services ended on 9/23/24, Resdient 247 was not given the SNF ABN form CMS-10055 or NOMNC form CMS-10123 by the provider prior to the end of his Medicare skilled services.
*Explanation on form CMS-20052 for why the above notifications were not given to resident 247 indicated, "in plan of correction."

The provider implemented actions to ensure the deficient practice does not reoccur. Plan of correction included SW P provided education to nurse manager D, DON B, and administrator A on SNF ABN and NOMNC completion. Beginning 10/25/24, administrator A or designee will audit each resident discharged to ensure SNF ABNs and NONMCs were completed timely. Findings

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F 582	Continued From page 3 from these audits will be reported to QAPI Committee. It was confirmed on 11/5/24 after record review revealed the facility developed a plan of correction and education was provided to those involved in SNF ABN and NOMNC issuance. Based on the above information, non-compliance at F582 occurred on 10/11/2024, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/2024, the non-compliance is considered past non-compliance.	F 582		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), record review, interview, and policy review the provider failed to ensure 25 of 25 sampled residents on Promise Lane (1,2,3,5,6,7,8, 9, 10,	F 600	On 10/7/2024 in response to CNA N report DON B reviewed the medication administration records of residents 3,14, and 38 and identified that the narcotics were noted by RN F as being administered On 10/7/2024 DON B verified that the narcotics were removed from the blister packs for residents 3, 14, and 38 and signed off by RN F in the facility narcotic book. On 10/7/2024 DON B checked the pain assessment completed by the nurses after RN F's shift (10/6/2024 night shift and 10/7/2024 day shift) and verified that pain level had not increased and was being properly managed per narcotic medication administration as ordered for residents 3,14, and 38.	12/06/2024

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F 600	Continued From page 4	F 600		

11,12, 13, 14, 20, 21, 22, 23, 25, 26, 27, 28, 36, 38, 39, and 40) had their blood sugar checked and received treatment and medications as ordered by one of one registered nurse (RN) F during a twelve-hour shift. Findings include:

1. Review of SD DOH FRI submitted on 10/9/24 revealed:
*"On 10/6/24 RN F had left her unit from 9:00 a.m. until 11:00 a.m. and staff were unable to locate her during this time."
*"Certified nursing assistant (CNA)/medication aide N had to remind RN F multiple times to give morning narcotics for three residents, but she never saw RN F go in or out of those rooms to give those medications, but they were signed off."

2. Review of the provider's investigation documentation indicated the 10/6/24 video camera footage was reviewed and revealed RN F:
*"RN Fon the unit at 6:27 a.m. Her shift began at 6:00 a.m. Then she:"
-"Counted the narcotics with off-going nurse at 6:42 a.m."
-"Left the unit at 8:17 a.m. and returned at 9:47 a.m."
-"Entered the narcotic medication drawer and retrieved all the narcotic blister packs from that drawer, and did something with them on the treatment cart, retrieved the narcotic sign out binder and was signing it."
-"Administered a medication at 4:56 p.m. to resident 36."
--"Only had been visualized via video camera administering medication to one resident throughout her shift."
-"Retrieved a medication at 4:58 p.m. from the top drawer of the medication and took it."

From 10/7/2024 through 10/10/2024 DON B reviewed Bethany security camera footage for the date of 10/6/2024 from 0600 to 1800 (RN F shift) and verified suspicion of RN F appearing to be under the influence and noted possible drug diversion as well as concerns regarding RN F whereabouts throughout the shift and questions regarding whether RN Fwas completing her assigned tasks. This resulted in DON B initiating a more widespread investigation beginning 10/8/2024 through 10/11/2024.

On 10/8/2024 DON B reviewed the medcation administration records of residents 1,2, 3, 5,6,7 8,9,10,11,12,13,14,20,21,22,23,25,26,27,28,36, 38,39,40 and verified that CNA N had administered all medications within her scope of practice to these residents on 10/6/2024.

On 10/11/2024 DON B completed a chart audit for every resident on the unit as of 10/6/2024 including residents 1,2,3,5,6,7,8,9,10,11,12,13, 14,20,21,22,23,25,26,27,28,36,38,39,40 to identify any treatments that should have been completed and the possibility of any documented adverse effects of not receiving their scheduled treatments, insulin, or blood sugars and found no concerns other than and elevated blood sugar within normal parameters for residents 28,10,13,36. An elevated blood sugar outside of normal limits was noted for resident 6 and Avel eCare was notified with orders received for resident 6 on 10/6/2024.

On 10/11/2024 DON B interviewed RN E and verifited that residents 3 and 25 had no adverse effects of dressing change and/or wound treatment possibly not being completed on 10/6/2024 by RN F.

On 10/22/2024 Nurse Manager D interviewed resident 7 who stated that she had received her nebulizer treatment on 10/6/2024.

On 10/7/2024 RN F did not report to work.

On 10/8/2024 DON B suspended RN F regarding allegation of diversion and neglect.

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-"Gave report at 6:11 p.m. to on-coming nurse."
-"Counted the narcotics at 6:20 p.m. with the on-coming nurse."
-"The count was correct."

3. Review of the provider's 10/11/24 resident chart audit for the resident's RN F had been responsible for during her 10/6/24 shift revealed:
*Resident 1 should have had a lidocaine 4% patch (for pain) applied to both of her shoulders.
*Resident 2 should have had an Aspercreme 4% patch (for pain) applied to her lower back and Voltaren gel (for pain) to her hands at 8:00 a.m. and 12:00 p.m.
*Resident 3 should have had the dressing changed to her right leg incision and Oxycodone 2.5 milligrams (mg) (for pain) given at 8:00 a.m. and 12:00 p.m.
*Resident 5 should have had her blood sugar checked at 7:00 a.m. RN F had documented the resident's blood sugar result 103 mg/deciliter (dL).
*Resident 6 should have had applied Triad paste (for wound healing) applied to her bottom, received Tresiba insulin 35 units subcutaneously, and had her blood sugar checked three times and had insulin administered to her based on her sliding scale subcutaneously as needed. RN F had documented the resident's blood sugar results as:
-At 8:00 a.m. 201 mg/dL and had administered six units of sliding scale insulin.
-At 11:00 a.m. 201 mg/dL and had administered six units of sliding scale insulin.
-At 5:00 p.m. 203 mg/dL and had administered six units of sliding scale insulin.
--At 9:00 p.m. 600 mg/dL. Avel e-health had been notified and orders received for extra insulin.
*Resident 7 should have had been given a

F 600

On 10/7/2024 DON B provided a personal in-service and coaching for CNA N on the importance of reporting and advised her that the concerns that had regarding RN F on 10/6/2024 should have been reported to the on-call manager immediately.

On 10/9/2024 DON B notified the SD DOH regarding RN F leaving the unit, suspicion of drug diversion, and resident neglect by RN F.

On 10/11/2024 DON B notified the SFPD regarding suspicion of diversion and neglect by RN F.

On 10/11/2024 DON B, Administrator A, and Nurse Manager D contacted BHSF Medical Director to inform him of RN F leaving the unit, suspicion of diversion on 10/6/2024, and the possibility of narcotics and insulins not being administered by RN F on 10/6/2024, and the possibility of blood sugars not being checked, and the possibility of treatments not being completed by RN F on 10/6/2024. Advised by the Medical Director to notify the physician of every resident identified.

On 10/11/24 Nurse Manager D notified the physician for residents 1,2,3,5,6,7,8,9,10.11,12 13,14,20,21,22,23,25,26,27,28,36,38,39,40 of the possibility of narcotics and insulins not being administered by RN F on106/24 and the possibility of blood sugars not being checked and the possibility of treatments not being completed by RN F on 10/6/24.

On 10/11/2024 DON B and Administrator A contacted the Avera LTC Pharmacy to report the suspected drug diversion and to review the "Drug Diversion" policy and found it to be correct. A complete review of the polilcy was completed to assure that all appropriate actions had beeen taken.

On 10/11/2024 DON B accepted RN F resignation.

On 10/14/2024 DON B initiated that she or her designee will complete an ongoing narcotic count audit on Promise Lane at random times during the day to ensure that the narcotic count is accurate, all signatures present, and no concerns identified twice a day x 1 week, then daily x 1 week, the 3 x a week x 1 month, then once a week thereafter. The DON or her designee will report findings to the the quarterly QAPI committee for as long as the committee deems necessary.

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F 600

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Brovana 15 micrograms (mcg) nebulizer (for breathing problems) at 8:00 a.m. and a budesonide 0.5 mg nebulizer (for breathing problems) at 8:30 a.m. and 3:30 p.m.
*Resident 8 should have had a Lidocaine 4% patch (for pain) applied to his back in the morning.
*Resident 9 should have had Vaseline applied to her lips.
*Resident 10 should have been given a Duoneb unit dose nebulizer (for breathing problems) at 7:00 a.m., 11:00 a.m., and 5:00 p.m., Humulin 14 units subcutaneously at 8:00 a.m. and six units subcutaneously at 6:00 p.m.
-RN F had documented the resident's blood sugar results as:
--At 7:00 a.m. 103 mg/dL.
--At 11:00 a.m. 103 mg/dL.
--At 5:00 p.m. 103 mg/dL.
*Resident 11 should have been given a Biscodyl suppository (for constipation).
*Resident 12 should have had Triad paste (for wound healing) applied to her bottom.
*Resident 13 should have been Lantus insulin 48 units subcutaneously at 7:00 a.m. and 5:00 p.m., blood sugar checks three times, Aspercreme 4% (for pain) ointment to her hands, and Lidocaine 4% patch (for pain) to both the resident's knees.
RN F documented the resident's blood sugar result and sliding scale Novolog insulin administered as:
-At 7:00 a.m. 243 mg/dL and administered four units of insulin subcutaneously.
-At 11:00 a.m. 243 mg/dL and administered four units of insulin subcutaneously.
-At 5:00 p.m. 133 mg/dL with no sliding scale insulin administered.
*Resident 14 should have had a Lidocaine 4% patch (for pain) applied to her lower back and

F 600

On 10/14/2024 the DON B filed a complaint with the SD Board of Nursing regarding RN F leaving the unit and suspicion of diversion and neglect of residents by RN F.

Beginning 10/16/2024 through 11/5/2024 DON or her designee notified residents 1,2,3,5,6,7, 8,9,10,11,12,13,14,20,21,22,23,25,26,27,28, 36,38,39,40 or their family members depending on cognitive status of the possibility of narcotics and insulins possibly not being administered by RN F on 10/6/2024 and/or the possibility of blood sugars not being checked and/or the possibility of treatments not being completed by RN F on 10/6/2024

On 10/22/2024 DON B and Administrator A reported the drug diversion and neglect incident along with the narcotic count audit to the QAPI committee.

On 11/14/2024 DON B and the Staff Develop. Coordinator completed education for all CNAs on "Mandatory Reporting"including the need to immediately report any suspicion of a staff member being under the influence and/or being absent from the unit for an extended period of time.

On 11/21/2024 DON B and her designees completed education for all nurses on documentation expectations and consequences of false documentation.

On 11/26/2024 the Administrator, DON, and Interdisciplinary Team in collaboration with the Medical Director created the "BHSF Abuse, Neglect, Exploitation and Misappropriation Prevention Program" policy which includes direction for "watching out for the care team to alleviate or prevent the potential for resident abuse or neglect.

On 11/26/2024the Administrator, DON,and IDT in collaboration with the Medical Director created the "Identifying Neglect", "Identifying Exploitation, Theft, and Misappropriation of Resident Property", "BHSF Identifying Types of Abuse" , and the "BHSFIdentifying Sexual Abuse and Capacity to Consent policies to

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F 600	Continued From page 7 Oxycodone 2.5 mg orally at 8:00 a.m. *Resident 20 should have had his scalp cleansed and had a dressing applied. *Resident 21 should have had barrier cream applied to her coccyx. *Resident 22 should have had Calmoseptine cream (a skin protectant) applied to her buttock. *Resident 23 should have had her blood checked at 7:00 a.m. -RN F had documented a blood sugar result of 199 mg/dL. *Resident 25 should have had a dressing changed to his feet, Mupirocin cream (antibiotic) applied to his first and second toes, Ketoconazole 2% (antifungal) cream applied to his face, and Ketoconazole 2% shampoo to his scalp. *Resident 26 should have had Triad paste (for wound healing) applied to her buttock, a Duoneb unit dose nebulizer (for breathing problems), and a Pulmicort 0.5 mg nebulizer (for breathing problems) at 10:00 a.m. and 6:00 p.m. *Resident 27 should have had Lantus insulin 42 units subcutaneously, her blood sugar checked at 7:00 a.m. and 5:00 p.m. RN F had documented the following blood sugar results as: -At 7:00 a.m. 199 mg/dL. -At 5:00 p.m. 103 mg/dL. *Resident 28 should have had Levemir 25 units of insulin subcutaneously, zinc oxide ointment to her buttock, and a blood sugar check. RN F had documented a blood sugar result of 102 mg/dL. *Resident 36 should have her blood sugar checked three times with sliding scale Humalog insulin administered as needed with blood sugar checks. RN F had documented resident's blood sugars results as: -At 7:00 a.m. 101 mg/dL with no sliding scale insulin administered. -At 11:00 a.m. 101 mg/dL with no sliding scale	F 600	to clearly define what constitutes abuse and negligence. On 11/26/2024 the Administrator, DON, and Nurse Managers created the "BHSF Resident and Employee Accountability Procedure" to establish a process that identifies the person responsible for regular rounding (documented on the daily door sheet) on all shifts to assure the presence and well-being of both staff and residents. The procedure also requires the completion of a rounding checklist. Beginning 12/2/2024 the DON or her designee will provide education for all staff on the "BHSF Abuse, Neglect, Exploitation, and Misappropriation of Resident Property" "BHSF Types of Abuse", "BHSF Identifying Sexual Abuse and Capacity to Consent", and the "BHSF Resident and Employee Accountability Procedure". Education will be completed by 12/6/2024. Beginning 12/6/2024 the DON or her designee will audit the door sheet every day to ensure that the person responsible for regular rounding is identified. The DON or her designee will report findings to the quarterly QAPI committee for as long as the committee deems necessary. Beginning 12/6/2024 the DON or her designee will audit the "Resident and Staff Rounding Checklist" daily x 4 weeks and then weekly thereafter to ensure its completionand to address any areas of concern. The DON or her designee will report findings to the quarterly QAPI committee for as long as the committee deems necessary.	

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F 600	Continued From page 8 insulin administered. -At 5:00 p.m. 133 mg/dL with no sliding scale insulin administered. *Resident 38 should have had Biofreeze (for pain) applied to both of his knees, Lidocaine 4% gel (for pain) applied to the lower back, and Oxycodone 5 mg orally at 8:00 a.m. and 12:00 p.m. *Resident 39 should have had Benadryl cream (for pain and itching) applied to both arms and legs. *Resident 40 should have had a blood sugar checked. RN F had documented a result of 103 mg/dL. 4. Interview on 11/7/24 at 2:40 p.m. with director of nursing (DON) B regarding the investigation regarding RN F's care of residents on 10/6/24 revealed: *DON B had reviewed the video footage for 10/6/24 involving RN F. *DON B had been able to verify RN F had not entered the above listed residents' rooms during her shift to provide the documented cares and medications. *She had interviewed other staff that had provided care for residents on the unit RN F had been assigned to on 10/6/24. -Those interviews had verified RN F had not been seen entering the above resident's rooms. *Education would be provided to all CNA's on 11/14/24 regarding the investigation results from this incident. *Education would be provided to all nurses on 11/21/24 regarding the investigation results from this incident. Review of the provider's November 2023 Prevention of Resident Abuse, Neglect, and	F 600		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 Misappropriation of Resident Policy revealed: *"Each resident living at Bethany has the right to be free from abuse, neglect, and misappropriation of their property. Bethany will enforce policies and procedures that protect each resident from abuse, neglect, and misappropriation of property by Bethany employees, other residents, consultants, volunteers, employees of other agencies serving the resident, family members and legal guardians, friends or other individuals." *"Bethany will not tolerate the abuse, neglect, or misappropriation of property of any resident by any employee, a consultant, or others working under the direction of Bethany." The video surveillance for 10/6/24 was not made available for survey review during the survey.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F 623		

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F 623	Continued From page 10	F 623		

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and

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F 623	Continued From page 11 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the	F 623	Past noncompliance: no plan of	

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F 623	Continued From page 12 provider failed to provide a written notice of transfer or discharge and to notify the ombudsman of that transfer or discharge, for two of two sampled residents reviewed (31 and 45). This citation is considered past non-compliance based on review of the corrective actions the provider implemented after discovering the lack of documentation. Findings include: 1. Interview and record review on 11/5/24 at 11:51 a.m. with administrator A revealed: *Administrator A provided the survey team with a copy of their investigation timeline and their plan of correction (POC) documentation. *They discovered a lack of documentation for a variety of required notices on 10/11/24. *The management team completed an investigation to determine the extent of the issue. *The previous social worker was responsible for providing required notices to residents or their representatives. That former employee was not providing the required written notices, including transfer or discharge notices. *The nurse managers were educated on the required written notices on 10/16/24. *Chart reviews were conducted, and corrections were completed. 2. Review of resident 31's electronic medical record (EMR) revealed: *She was transferred to the local emergency department on 5/24/24, and again on 9/1/24. *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified for either date. 3. Review of resident 45's electronic medical record revealed:	F 623	correction required.	

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F 623	Continued From page 13 *She transferred to the local emergency department on 8/12/24. *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified. 4. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about the required notices revealed that she was not sure if the notices were completed correctly due to an issue with the previous social worker. 5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse managers about required notices, interviews revealed staff understood the education provided regarding those topics, and a review of recently transferred or discharged residents revealed notices were provided as required. Based on the above information, non-compliance at F623 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance is considered past non-compliance.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to	F 625		

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F 625	Continued From page 14 the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the provider failed to provide a written bed-hold notice to the resident or their representative when transferred to the emergency department for one of two sampled residents reviewed (45). This citation is considered past non-compliance based on review of the corrective actions the provider implemented after discovering the lack of documentation. Findings include: 1. Interview and record review on 11/5/24 at 11:51 a.m. with administrator A revealed: *Administrator A provided the survey team with a copy of their investigation timeline and plan of	F 625	Past noncompliance: no plan of correction required.	

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F 625	Continued From page 15 correction (POC) documentation. *They discovered a lack of documentation for a variety of required notices on 10/11/24. *The management team completed an investigation to determine the extent of the issue. *The previous social worker was responsible for providing required notices to residents. That former employee was not providing the required written notices, including bed hold notices. *The nurse managers were educated on the required written notices on 10/16/24. *Chart reviews were conducted, and corrections were completed. 2. Review of resident 45's electronic medical record revealed: *She admitted to the facility on 7/23/24. *She transferred to the local emergency department on 8/12/24. *The social worker spoke with the resident's representative about the bed hold policy on 8/12/24. Written notice was not documented. *The resident's representative verbally declined to hold the bed and gathered resident 45's belongings from the facility on 8/12/24. 3. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about bed hold notices revealed: *The written bed hold notices were "unlikely to have been done" due to a situation with the former social worker. *The resident had not requested to return to the facility as she was admitted to hospice services. 4. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse	F 625		

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F 625	Continued From page 16 managers about required notices, interviews revealed staff understood the education provided regarding those topics, and a review of recently discharged residents revealed notices were provided as required. Based on the above information, non-compliance at F625 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance is considered past non-compliance.	F 625		
F 657 SS=D	Care Plan Timing and Revision 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.	F 657	On 11/25/2024 the DON added the diagosis of dementia to resident 11 care plan. on 11/27/2024 during the review of resident 11 comprehensive care plan it was noted that the Seroquel was not on the medication review as the medication was discontinued on 11/12/2024. The focus for Seroquel was not added to the care plan due to it being discontinued. On 11/25/2024 the DON added the focus of Apixaban to resident 25 care plan related to blood clot prevention. On 11/25/2024 the DON reviewed the "Plan of Care" policy and found it to be correct. On 11/26/2024 the DON will provide education to all nurse managers, the social worker, and the MDS Coordinator on the "Plan of Care" policy. Beginning 11/26/2024 the DON or her designee along with the IDT will review all current comprehensive care plans ensuring that the diagnosis list and medication review are reconciled in the care plan.	12/6/2024

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F 657	Continued From page 17 (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 record review, interview, and policy review, the provider failed to ensure the care plan for two of two sampled residents (11and 25) had been updated to reflect their current condition. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *On 8/6/24 she had received a diagnosis for dementia and other diseases classified elsewhere. *On 8/15/24 an order had been received to start Seroquel 100 milligram (mg) by mouth one time a day related to Major Depressive Disorder. 2. Review of resident 11's care plan revealed: *On 8/20/24 the care plan had been updated and indicated the use of scheduled psychotropic medications related to pain management and depression. No focus area on resident's diagnosis of dementia was noted in the care plan. 3. Review of resident 25' s EMR revealed: *On 8/23/24 an order had been received to start Apixaban 2.5 mg (blood thinner) for Atrial fibrillation by mouth two times per day for blood clot prevention. 4. Review of resident 25's care plan revealed: *On 10/29/24 the care plan had been updated but did not indicate that the resident was started on Apixaban 2.5 mg, for the prevention of blood clots.	F 657	Beginning 12/6/2024 the DON or her designee will meet monthly to review the comprehensive care plans of the residents in their quarterly review window to ensure all diagnosis and the medication review items are in the comprehensive care plan. Beginning 12/6/2024 the DON or her designee will audit 3 residents weekly to ensure all diagnosis and the medication review items are on the comprehensive care plan. The DON or her designee will report findings to the quarterly QAPI committee for as long as the committee deems necessary.	

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F 657	Continued From page 18	F 657		

5. Interview on 11/7/24 at 2:15 p.m. with director of nursing B, nurse manager D, and administrator A revealed:
*The manager of each unit is responsible for updating the residents' care plans.
* Any staff member who processes an order, is also responsible for updating the care plan.
* During the interview, administrator A, DON B, and nurse manager D agreed that residents 11 and 25's care plans had not been updated to reflect their care needs.

Review of the provider's October 2024 Care Plan policy revealed:
* "Care Plans will be updated by staff on an ongoing basis. This includes care plans being reviewed and updated with appropriate significant changes as well as quarterly. Significant changes could include recent hospital stays, new admissions to hospice, new acute diagnosis, and other traits that reflect a decline is physical and emotional status."
* "The nurse manager will complete a daily process such as daily walking event rounds, daily review of all new orders, daily review of 24-hour sheets, daily review of progress notes and/or daily review at IDT huddle in order to keep the care plan current. The nurse manager will utilize the plan of care to create CNA's daily/weekly care flowsheets."

F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7)	F 803		

§483.60(c) Menus and nutritional adequacy. Menus must-

§483.60(c)(1) Meet the nutritional needs of

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F 803	Continued From page 19 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: Based on menu review, observation, and interview, the provider failed to ensure adequate portions were served according to the menu for one of one observed meal. This had the potential to affect all residents receiving the main menu in the facility. Findings include: 1. Review of the provider's menu for lunch on 11/7/24 revealed the following main menu items: *Beef & broccoli, "#8 dip x2," which was eight ounces (oz.) total. *Diced carrots, "four oz. spoodle." -A spoodle is a slotted scoop to drain the liquid.	F 803	On 11/21/2024 the Dietary Manager G, Dietician, and Administrator in collaboration with the Medical Director reviewed the "Portion Control Policy" and revised it to include the need to ensure that the appropriate serving size is what is served out unless the resident has made a choice/ preference for a different portion size. On 11/21/2024 the Dietician provided a personal in-service educaiton with return demonstration on the "Portion Control Policy" to Dietary Manager G. On 11/22/2024 the Dietary Manager G and the Dietician reviewed the weekly menu with extentions and found it to be correct. On 11/22/2024 Dietary Manager G confirmed that the kitchen was stocked with the correct portion sized serving utensils to correlate with the weekly menu with extensions. On 11/25/2024 Dietary Manager G provided a corrective action and personal in-service education with return demonstration to cook L on the "Portion Control Policy". Beginning 11/22/2024 Dietary Manager G will provide education with return demonstration to all cooks on the "Portion Control Policy" Beginning 12/2/2024 Dietary Manager G or her designee will complete an obervation audit of trayline at varying meal service times on a daily basis x 4 weeks and then weekly thereafter. Dietary Manager G or her designee will report findings to the quarterly QAPI committee for as long as the committee deems necessary.	12/6/2024

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F 803	Continued From page 20 2. Observation on 11/7/24 at 11:11 a.m. in the kitchen during lunch service revealed: *Cook L was plating the residents' lunch meal food items. *She served a three oz. scoop of the beef & broccoli. -The printed menu indicated the serving size for the regular diet as #8 dip x 2. *Cook L served a heaping two oz. spoodle of diced carrots. -The printed menu indicated the serving size as 4 oz. *Observation of the utensil drawer confirmed that a 4 oz. spoodle and a 4 oz. serving spoon were available. 3. Interview on 11/7/24 at 1:29 p.m. with cook L revealed she: *Was aware of the serving sizes on the printed menu. *Chose not to use the correct serving sizes; she did not provide a reason. 4. Interview on 11/7/24 at 1:34 p.m. with dietary manager G about the above observations revealed she: *Was not aware that dietary staff served the wrong portion sizes for lunch that day. *Was aware of the need to meet the dietary requirements of the residents by following the approved menu, including portion sizes.	F 803		
F 812 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	F 812		

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F 812	Continued From page 21 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, and document review, the facility failed to maintain cleanliness in one of one steamer and one of one convection oven in the kitchen. Findings include: 1. Observation during the initial kitchen tour on 11/5/24 from 11:43 a.m. to 12:19 p.m. revealed: *The interior of the Vulcan brand convection oven was heavily coated in baked-on grease and food particles. *The interior of the Cleveland brand SteamChef steamer had an excessive buildup of limescale and scum, and there were food particles at the bottom of the basin sitting in standing water. 2. Interview on 11/7/24 at 10:45 a.m. with cook L about cleaning the large kitchen equipment revealed: *She claimed that she cleaned the steamer and oven every day, and deep-cleaned them weekly. *That equipment had not been deep-cleaned in	F 812	On 11/21/2024 Dietary Manager G cleaned the Vulcan brand convention oven. On 11/21/2024 Dietary Manager G determined the need to remove the Cleveland brand SteamChef steamer from service due to its age. Dietary Manager G determined not to replace the steamer due to the infrequency of its use in food preparation. On 11/21/2024 Dietary Manager G in collaboration with the Dietician and the Administrator reviewed the manufacturer's instructions regarding cleaning the Vulcan brand convection oven and found them to be correct. On 11/21/2024 Dietary Manager G, Dietician Medical Director, and Administrator created the "Oven Cleaning Procedure" based on the manufacturer's instructions and that states the need to ensure that all food preparation equipment is maintained in a clean and sanitary manner for all users. On 11/21/2024 the Dietician provided Dietary Manager G with a personal in-service with return demonstration on the "Oven Cleaning Procedure" and stressed that it is all food preparation employee's responsibility to ensre that all kitchen equipment and appliances are well-maintained, clean, and sanitary for use. On 11/21/2024 Dietary Manager G created a daily schedule for the Vulcan convection oven which also includes an every 2 week deep cleaning requirement. On 11/22/2024 Dietary Manager G inspected all kitchen equipment and appliances and found them to be clean and in good working order.	12/6/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING ______ B. WING ______	C 11/07/2024

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

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F 812	Continued From page 22 about a month. *She did not know the proper steps to clean the steamer. 3. Interview on 11/7/24 at 1:34 p.m. with dietary manager G about the oven and steamer revealed: *There was a cleaning schedule for the kitchen equipment. *She performed monthly audits for kitchen cleanliness. *She was unaware that the oven and steamer were that dirty. *She did not know the proper steps to clean the steamer. 4. Review of the provider's monthly kitchen cleanliness audits revealed: *The audits were completed on 8/26/24, 9/30/24, and 10/25/24. *There was a line item under the "Maintenance" section that read "Ovens and Steamer clean and in good repair." -There was a checkmark "Yes" next to that line item on the above-listed audit sheets. 5. Review of the manufacturer's cleaning guidelines for the Cleveland SteamChef revealed they recommended descaling daily to prevent the buildup of minerals and limescale. *"When done daily this will help prevent the buildup of calcium and other mineral deposits left over from the boiling of water, and prevent scale buildup in the steamer, helping prevent more costly maintenance and service on the steamer."	F 812	On 11/22/2024 Dietary Manager G reviewed the cleaning schedule for all other kitchen equipment and appliances and found it to be correct On 11/25/2024 Dietary Manager G provided a personal in-service with return demonstration on the "Oven Cleaning Procedure" to cook L. On 11/25/2024 Dietary Manager G provided cook L with a personal in-service regarding the daily cleaning schedule and the two-week deep cleaning requirment. Beginning 11/22/2024 Dietary Manager G will provide education to all cooks on the "Oven Cleaning Procedure" with return demonstration. Beginning 11/22/2024 Dietary Manager G will provide education to all cooks on the Vulcan oven cleaning daily schedule and every two week deep cleaning requirment. Beginning 12/2/2024 Dietary Manager G or her designee will audit the Vulcan convection oven daily cleaning and two week deep cleaning schedule including an oven inspection daily x 4 weeks and then weekly thereafter. Dietary Manager G or her designee will report findings to the quarterly QAPI committee for as long as the committee deems necessary.	

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

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	435096	A. BUILDING ______ B. WING ______	11/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME SIOUX FALLS	1901 SOUTH 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) COMPLETION DATE
E 000	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 11/6/24. Bethany Home Sioux Falls was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Herrboldt
TITLE: Administrator
(X6) DATE: 11/27/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**11/06/2024**

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

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K 000	INITIAL COMMENTS A recertification survey was conducted on 11/06/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethany Home Sioux Falls was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Herrboldt	Administrator	11/27/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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 ______	11/07/2024

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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 11/5/24 through 11/7/24. Bethany Home Sioux Falls was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 11/5/24 through 11/7/24. Bethany Home Sioux Falls was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Herrboldt	Administrator	11/27/2024