STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	129 W HWY 12 WEBSTER, SD 57274

(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 1/7/25 through 1/9/25. Bethesda Home was found not in compliance with the following requirements: F583, F585, and F684. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/7/25 through 1/9/25. Areas surveyed included accident hazards related to facility heater vents and quality of care by staff related to alleged illegal drug use. Bethesda Home was found in compliance.	F 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other	F 583	Smart speaker/video monitoring signage was posted on 1/9/2025 and consents were completed for affected residents and roommates by 1/29/2025. Education for residents, roommates, family and staff was provided related to smart speaker/video monitoring devices and privacy. Care plans were reviewed and revised and are up to date to reflect the use of speaker/video monitoring devices in the identified residents #1, 12, 20, 25, 37and 42. Audit of all other residents was completed on 1/9/2025 to ensure no additional deficient practice with smart speaker/video monitoring devices. No other residents have been identified with smart speaker/video monitoring devices. Education has been provided to staff, residents, and families related to facility smart speaker/video monitoring policy/policies. The Smart Speaker/video Device Policy and Protocol has been updated to reflect these changes and reviewed by the medical director by 1/31/25. The policy identified as "Video/Audio Monitoring policy" is used for security of the facility and not related to personal smart devices. This policy was not changed. All licensed and unlicensed staff were provided with education related to their responsibilities to maintain privacy and confidentiality for residents utilizing smart speaker/video monitoring devices.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Cunningham | TITLE: Administrator | (X6) DATE: 2-4-2025

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 583	Continued From page 1 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review, and policy review the provider failed to ensure practices were in place to ensure the residents' right to privacy for six of six (1, 12, 20, 25, 37, and 42) sampled residents with audio and video monitoring devices in their rooms. *Obtain consent for audio and video monitoring use for six of six (1, 12, 20, 25, 37, and 42) sampled residents with audio and video monitoring devices in their rooms. Findings include: 1. Observation on 1/7/25 at 2:18 p.m. of residents' (12 and 37) room revealed: *An Alexa device with a screen was sitting on the over-the-bed table beside a recliner. *The device was on. *The screen displayed the current weather. *There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. 2. Resident group interview on 1/8/24 at 1:25 p.m. revealed:	F 583	Social Services coordinator has added education to admission packets regarding smart speaker/video monitoring devices ensuring all new residents and families are informed and consents are available for signatures if applicable upon admission. Administrator or designee will complete monitoring audits weekly for 4 weeks and monthly for 3 months. Audits will be taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	2/7/2025

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F 583	Continued From page 2 *Resident 10 was the resident council president and started the meeting reviewing "the resident rules". -The "rule" addressed at that time was regarding video monitoring. *Resident 10 stated, "We don't do that, I don't think". *She asked if the other resident present had heard or seen video monitoring, but there was no response. 3. Interview on 1/9/25 at 9:29 a.m. with certified nursing assistant (CNA) L revealed: *She was unaware of any video or auditory monitoring devices in residents' rooms. *There were devices in residents' rooms used to make and receive calls. *Some of the devices had video screens. *She was unaware that some devices had the ability, for someone outside the facility, to listen to what was happening in the room. 4. Interview on 1/9/25 at 9:57 a.m. with registered nurse (RN) I revealed: *She was unaware of any video or auditory monitoring devices in residents' rooms. *Some residents had "Alexa" devices in their rooms. *She was unaware that some devices had the ability, for someone outside the facility, to listen to what was happening in the room. 5. Interview on 1/9/25 at 10:07 a.m. with licensed practical nurse (LPN) M revealed: *She was aware that some devices had the ability, for someone outside the facility, to listen into a resident's room with an Alexa-type device. *She identified residents 1, 12, 20, 25, 37, and 42 as having Alex-type devices.	F 583		

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F 583	Continued From page 3 *She stated that the provider supplied the devices in resident 25's and resident 42's rooms. *The other devices were provided by residents' families. 6. Observations and interviews on 1/9/25 between 1:22 p.m. revealed: *Resident 1 had two Alexa devices: -She had an Alexa Echo on her dresser and she stated she used it to listen to music. -She had an Alexa Echo Show on her over-the-bed table. --The Alexa Echo Show had a video screen. --She stated that she used that device to call her family. -There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. *Residents 12 and 37 shared a room. -An Alexa Echo Show was on an over-the-bed table beside a recliner. -Resident 12 stated that they used it to make video calls to family and to check the weather. -There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. *Resident 20 had an iPad on her over-the-bed table. -She stated she used it to make video calls. -There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. *Resident 25 had an Alexa Echo Pop on her shelf. -Music was playing on the device. -There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. *Resident 42 had an Alexa Echo Pop on her	F 583		

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F 583	Continued From page 4	F 583		

bedside table.
-Music was playing on the device.
-There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room.
7. Interview on 1/9/25 1:55 p.m. with DON B regarding audio video monitoring devices in resident rooms revealed:
*She stated all of the devices were put into place in the last month.
-Resident 1 used her's to make phone calls.
-She was not aware residents 12 and 37 had a device.
-They were mostly used for psychosocial reasons such as playing music.
-She was not aware the devices had a "drop in" feature (when a someone with access to the device, was able to initiate video monitoring without the residents or staff knowledge).
-They did not have residents sign an informed consent form.
-She had "recently" developed a written a policy for audio and video monitoring devices.
-She confirmed the audio and video monitoring device policy was written on 1/8/25 an not on 1/8/24.

8. Review of the 11/2020 South Dakota State Long-Term Care Ombudsman Program resident rights handbook the provider includes in their admission packet for newly admitted residents revealed:
*"Video monitoring device -a camera or other device, which captures, records or broadcasts video and which is placed in a resident's room and used to monitor the resident or activities in the room."
*"Before initiating video monitoring, a resident shall complete and submit to the facility a notice

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F 583	Continued From page 5 and consent form ..." *"The facility shall post conspicuous signage at the entrance to the resident's room indicating that the room is being monitored by means of a video monitoring device." 9. Review of the provider's 12/3/24 Video/Audio Monitoring 'policy revealed "Video and audio monitoring are not allowed in resident rooms and bathrooms." 10. Review of the provider's 1/8/24 (1/8/25 per DON B interview) Alexa Device Policy revealed: *"The facility has the responsibility and authority to manage, monitor, and establish protocols for the use of the Alexa devices. -Protocols may be amended, and be communicated, as resident interests, staff ability, and technology changes." *"This policy does not supersede nor negate existing policies addressing, but not limited to the following -The facility values and standards of behavior are not compromised." 11. Review of the provider's undated Personal Smart Device Protocol revealed: *"Devices may be initiated by facility for psychosocial reasons *Devices may be initiated by family for connectivity".	F 583		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or	F 585	Concern forms were written, investigated, followed up on and resolved for the concerns of residents identified as resident# 10 and resident# 32.	

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F 585	Continued From page 6 reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency,	F 585	The facility grievance policy has been reviewed and revised by the IDT and Medical Director on 1/31/25. All licensed and unlicensed staff were educated on the policy and procedure for assisting residents with filing grievance. All staff and residents have been informed of the location of the suggestion/concern forms. A suggestion and concern box was hung at the nurses station for anonymous filing of grievances. The Administrator and/or the grievance officer designee will review all grievances and collaborate with the department supervisor for prompt resolution per policy going forward. A grievance tracking document will be utilized to ensure timely follow up. All grievances will be investigated, resolved, and followed up with the resident within 7 days. Resident council grievances will be written by the department supervisor in attendance within 24 hours. Those grievances will be added to the tracking document and distributed to the department supervisor, the grievance officer, and the administrator for tracking, timely follow-up, and prompt resolution. Written communication will be provided to the party concerned, outlining the steps taken to resolve the concern within 7 days. Grievance resolution will also be reviewed with the resident council at the next scheduled meeting. All suggestions, concerns, and grievances investigation and follow-up will be filed with the grievance officer and these documents will be maintained in the facility for a minimum of 3 years. All suggestions, concerns, and grievances will be traced and trended in the monthly I QAPI meeting. The administrator or designee will assign and complete intentional resident rounding/Angel round audits weekly for 4 weeks and monthly for 3 months. Audits will be taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	2/7/2025

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Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility

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F 585	Continued From page 8 or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, observation, record review, and policy review, the provider failed to implement an effective grievance process to ensure two of two sampled residents (10 and 32) who had reported grievances included documentation, investigation, and follow-up with the resident regarding issues of resident care and quality of life that were important to the resident. Specifically, the provider failed to ensure the following: *All written grievance decisions included the date that the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to have been taken by the provider as a result of the grievance, and the date the written decision was issued. *Prompt efforts to resolve grievances and to have kept the residents informed of progress toward the resolution. *Staff completed a grievance form if given an oral grievance, investigated, and followed up with the resident and their representative.	F 585		

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F 585	Continued From page 9 *The resident council was informed in writing of the responses to concerns brought up in the resident council meetings and provided a prompt update on efforts by the provider to resolve any grievances. Findings include: 1. Interview on 1/7/25 at 10:50 a.m. with resident 32 revealed she: *Had lived in the facility for close to three years. *Had concerns regarding the main dining room: -She felt the dining room was cold and she had to wear two sweaters when she went to the dining room for her meals. -She thought the air exhaust vent that was located on the wall close to her table was "filthy." -The menu board in the dining room, which listed what was being served, sometimes had food items listed that "you've never heard of" and she had no idea what that food item was. -She had discussed those concerns with staff but stated "Nothing was done." *Had concerns regarding the meals she was provided: -She was diabetic since childhood. -Stated she was a "picky eater" and had a list of things she could not eat, which included: --Oleo/margarine. --Mayonnaise. --Cheesy potatoes. --Chicken. -She had discussed her meal preferences with staff. -She stated those preferences were honored if the "right cook" was working. -There were times when those preferences were not honored and she was served something she could not eat.	F 585		

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F 585	Continued From page 10 2. Observation on 1/9/25 at 11:30 a.m. of the air exhaust vent on the wall next to resident 32's table revealed it was coated with dust particles that were easily removed with a finger swipe. 3. Interview and observation on 1/9/25 at 11:33 a.m. with dietary cook J revealed: *Dietary director E was not at work in the facility that day, 1/9/25. *She had not heard of any resident concerns regarding the posted menu. *She had visited with resident 32 regarding her food preferences and specific dislikes the resident had. *She revealed resident 32 disliked butter, margarine, luncheon meat, and chicken. *Observation of resident 32's dietary card with dietary cook J revealed the "Dislikes" section on her dietary card was blank. *The dietary card for each resident was referenced by the dietary cooks when preparing each resident's meal. 4. Review of resident 32's electronic medical record (EMR) revealed: *She had been admitted on 5/25/22. *Her diagnoses included diabetes mellitus type 2 and gastroesophageal reflux disease (GERD) with esophagitis, without bleeding. *Her Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *Her 11/18/24 care plan included a nutritional status section that included the following approaches: -"Regular Diet, Thin liquids. May request ground meat..." -"Offer tray set up assistance as needed at mealtime..."	F 585		

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F 585	Continued From page 11 -"Honor personal requests at all meals..." -No specific meal preferences or food dislikes were listed. 5. Review of the requested grievances from July 2024 through January 2025 received and recorded by the provider revealed two complaints/grievances were documented from resident 32: *A Safety Zone electronic "event form" for a verbal complaint on 8/12/24 received from resident 32 regarding her "Care/Treatment" and meals during an assessment interview with licensed social worker (LSW) H. -The electronic event form's "Follow up" section documented the following actions were taken: --Minimum data set (MDS) coordinator C addressed the resident's concerns regarding her care. --"The Dietary Manager followed up with [resident 32] on 8/16/24 to discuss food preferences, offering her 2nds, and the way the staff delivers her plate." --LSW H followed up with the resident's daughter on all these concerns. -There was no documentation regarding the resident or the resident's daughter's follow up's "Reaction to issue" having been either satisfied or dissatisfied. -There was no documentation regarding the follow up's "Expectations" of either: --"Apology." --"Better communication." --"Billing adjustment." --"Compensation." --"Doesn't want to happen to anyone else." --"Face to face." --"Notification to..." --"Talk with administration."	F 585		

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F 585	Continued From page 12 --or "Other." *A Safety Zone electronic "event form" for a grievance on 10/18/24 received from resident 32 regarding her care and her food preferences. -The electronic event form's "Follow up" section documented the following actions were taken: --Director of nursing B had followed up with the resident on 10/18/24 to address her care concerns. --Dietary director E had followed up with the resident on 10/22/24 to address her food preferences. -The follow up's "Reaction to issue" area was documented as satisfied. -The follow up's "Expectations" area was documented with: --"Apology." --"Better communication." *There was no complaint/grievance form that documented resident 32's concern regarding: -The dining room being cold. -The air exhaust vent that was located on the wall close to her table being "filthy." -The menu board in the dining room that at times listed food items not understood by the resident. 6. Interview on 1/7/25 at 4:41 p.m. with resident 10 revealed: *She was the current president of the resident council which met monthly to "listen to complaints and plan the meal of the month." *Activity director F helped to coordinate the resident council meetings and typed up the meeting minutes. *She was not sure how the complaints from the resident council were addressed. *Stated she had not seen a concern form when asked about the provider's suggestion/concern form.	F 585		

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F 585	Continued From page 13 *She was concerned that the dining room was cold. 7. Interview on 1/9/25 at 9:50 a.m. with LSW H revealed: *She was the provider's grievance official. *Resident and family grievances were directed to her and she completed an interview regarding the grievance and used the provider's electronic healthcare Safety Zone program to document the concern. *She reviewed the provider's paper suggestion or concern form when completing admission paperwork with the resident and family. *She was not aware of any difference between a complaint and a grievance in the provider's grievance policy. *Activity director F had been in her position for one year. -She was concerned that activity director F had not been adequately trained for her position. -She had not provided any training to activity director F regarding the grievance process. *She was aware that activity director F typed up the resident council meeting minutes and provided them to the department managers for follow-up. -She had not discussed with activity director F how to handle the concerns brought up at the resident council. *That day, 1/9/25 was LSW H's last day of work with the provider and she was not aware of any replacement, but stated that administrator A would figure it out. 8. Interview on 1/9/25 at 12:55 p.m. with activity director F and director of business D revealed activity director F: *Coordinated the monthly resident council	F 585		

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F 585	Continued From page 14	F 585		

meeting and would take notes at the meeting to assist her in documenting the meeting minutes, but stated she had not saved those notes after she had typed the meeting minutes.
*Would discuss verbally the concerns expressed at the meeting with the department manager responsible.
-She agreed this was a verbal discussion with no written communication regarding the concern.
*Had not reviewed "old business" from the previous meeting but had the resident council approve the previous month's meeting minutes.
-She agreed she had not reviewed resolutions to concerns expressed at the prior meeting.
-She agreed that the meeting format could be improved.
*Agreed the resident council meeting minutes had not documented resolution of the concerns expressed at prior meetings.
1. Interview on 1/9/25 at 1:44 p.m. with DON B regarding resident grievances revealed:
*When a resident had a grievance or complaint it was given to the social service department for follow-up.
-The social service department was able to "handle generic items by email or phone call."
-For complaints that the social service department was unable to take care of immediately, the social service department would notify the department manager related to the complaint for their assistance.
*For grievances related to the nursing department she would talk to the resident and try to figure out what the problem was and what was needed to provide a resolution to the problem.
*She stated, "We are missing that follow-up documentation" for grievance resolutions.
*Grievances would be documented in "Safety Zone" (an electronic tracking system).

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F 585	Continued From page 15 -Those items would be taken from verbal reports and resident's progress notes. -Staff members with access to Safety Zone were the MDS coordinator, dietary manager, infection control preventionist, licensed social worker, administrator, corporate administration, and herself. *Regarding all staff members becoming aware of resident grievances she indicated staff members would become aware through staff meetings, stand-up meetings that were held a couple of times a week, daily report at 2:00 p.m. and at 6:00 p.m., monthly CNA meetings, she would talk to and remind staff. *Her expectation was for all staff to know where grievance forms were located in order to assist residents in completing one. *For resident council grievances, she thought the grievance issue was followed, but there was no written or formal response to the residents. *There was no Grievance Committee. *There was a Quality Assurance committee meeting, grievances were not reviewed at these meetings. 1. Observation on 1/7/25 at 12:25 p.m. of lunch service revealed: *There were cards on the side of the serving table. *The cards were labeled with each resident's name. *There was an area on the card that indicated allergies, dislikes, and specialized diet orders. *Resident 9's card indicated she did not like broccoli. -Broccoli was served to her. 2. Interview on 1/7/25 at 4:08 p.m. with resident 10 revealed:	F 585		

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F 585	Continued From page 16 *She was the resident council president. *She felt that some residents did not express their concerns during resident council but talked about concerns before and after the meeting. *Activity director F coordinated the meetings and took notes at the meetings. *Resident 10 felt there was no follow-up on the concerns brought up during the resident council meetings. 3. Resident group interview on 1/8/24 at 1:25 p.m. revealed: *Resident 10 acted as the resident council president and in review of the last meeting asked if there were any questions about the state ombudsman then proceeded going through each facility department asking if any concerns. *During dietary department and food discussion, concerns expressed included: -"It's terrible." "We all have the same idea." -"Can't see how it can't be warm, the carrots could have just as well come out of the freezer." -Voiced they may be served broccoli five days in a row or another vegetable three times in a week, they wanted variety. -They had not been offered salad in three or four months and would like salad, but salad needed to be more than just lettuce. -One resident stated she was the first one in the dining room and the last one served. She stated that her tablemate fell asleep waiting for his food to be served. -Other's stated that they would like fresh fruit, fresh vegetables, and pickles. -One resident stated that she felt the kitchen was trying to "educate" the residents on new foods. She did not know what some of the dishes on the board were. --She felt the menu board should be simple, like	F 585		

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F 585	Continued From page 17 "chicken or fish" not "fritters". --She felt the menus were planned for people younger than "we are". *When the maintenance department was discussed one resident stated: -When something was requested there was no response. -She had told maintenance director N that the television in the dining room needed to be cleaned, he told her he did not know whose job that was. *She had told maintenance director N last fall and again a week "or so" ago the "register" (the heat register was clarified to be the air exhaust vent) in the dining room needed to be cleaned. *Concerns expressed related to staffing were: *One resident stated: -She had her call light on for over one hour before staff responded. -While she waited for the staff to answer her call light, she was incontinent of urine. -When she was incontinent, she "soaked" her clothing and her bedding. *Another resident stated: -She had been incontinent of stool while she waited for her call light to be answered. -She had witnessed more than one staff in the soiled utility room visiting with one another. *The residents expressed that staff followed up with them in regarding their expressed concerns but they did not feel anything changed. *A resident stated that she had brought up concerns at her care conference and she did not receive follow-up about her concerns. *A third resident stated that he did not feel that he would be retaliated against if he brought up a concern but did state that the staff made the residents feel like they "dislike" them if they expressed a concern.	F 585		

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F 585	Continued From page 18 -He clarified this to be the most noticeable to him on the evening shift. *Another resident stated that he was offered evening snacks at times, but not every night. *The residents present in the group interview stated they were unaware of where to find a grievance form but no one had ever filled one out. 4. Interview on 1/8/25 at 3:30 p.m. with activity director F about resident council revealed: *Some concerns were brought up repeatedly. *Food was often a concern expressed. *She was told by "management" not to include detailed information in the resident council meeting minutes. *She followed up on resident concerns by asking the residents if there was a change. *Previously, residents stated that a concern was better, and then later would state nothing had changed. *The concerns that the residents brought up during resident council were not concerns she had not heard previously. *She was unaware that the concerns had not been addressed. *She had not filled out grievance forms for resident concerns. *She sent an email to each manager about the concerns that needed to be addressed. 5. Observation on 1/8/25 at 3:42 p.m. of the television and the air exhaust vent in the dining room revealed: *There were fingerprints and smudge marks on the television. *The air exhaust vent had gray and black dust particles on the vent cover. *The cavity behind the vent cover revealed the majority of the surface area was covered in gray	F 585		

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F 585	Continued From page 19 dust particles. 6. Interview on 1/8/25 at 4:39 p.m. with dietary director E revealed: *She received emails from activity director F with concerns brought up during resident council and the selected meal for the month. *She followed up with the resident who expressed the concern. *She stated that the concern expressed today (1/8/25) during resident council about not having had lettuce in the last three to four months was untrue. It had only been one to two months. *She stated that she did not understand how the carrots during lunch could have been cold they "were temped" (food temperature was taken before they were served). 7. Interview on 1/9/25 at 9:29 a.m. with certified nursing assistant (CNA) L revealed: *If a resident came to her with a complaint or concern, she would have: -Listened to the concern. -Addressed the concern if she was able. -Reported the concern to the charge nurse. *She knew that there were grievance forms, but did not know where they were located. *She had not filled out a grievance form. 8. Interview on 1/9/25 at 9:53 a.m. with registered nurse (RN) I revealed: *She would notify the director of nursing (DON) or the administrator if a resident came to her with a concern. *She had not filled out a grievance form. *She did not know where the grievance forms were located. 9. Review of the resident council meeting minutes	F 585		

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F 585	Continued From page 20 from July through December, 2024 revealed: *Old business was not identified as part of the meeting in any of the monthly minutes. *July's concerns were: -Laundry items were missing and put in the wrong places. -Dietary menu "to be switched up". *There were no concerns in August, but the resident council was informed a new labeler was being purchased for laundry. *In September the resident council requested the dietary manager to be present at their next meeting. *In October resident council "Talked with Dietary Manager. Nothing new to report". *In November there was "nothing new to report" for all departments. *In December there was "nothing new to report" for all departments. 10. Review of the emails sent from activity director F to the managers, addressing the resident council concerns from July to December 2024 revealed: *The 7/22/24 email stated: -Resident 32 not enjoying her current room because of her window view and would like to be notified of any room openings down B or C hall for her to look at and possibly switch rooms. -Housekeeping supervisor O- "residents had a complaint with housekeeper P not cleaning anything in their rooms, and just doing the floors." -Dietary director E- residents stated, there is BBQ everything and would like a change, and sides switched. -The back patio was not what was recommended by them when asked for their input. For most residents it is not accessible alone, due to the decline on the sidewalk, and also the back door	F 585		

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F 585	Continued From page 21 entrance they want leveled out. *The 8/2/24 email to dietary director E stated: -"Can you switch resident 1's breakfast card to say cream of wheat instead of oatmeal? I mentioned it the other week to the cook, but no one had done it yet". *The 8/22/24 email to dietary director E stated: -Some residents were not happy with dessert today. --They received ice cream instead of cherry pie. They stated they were not informed why the dessert was switched. -Can you add the DAY OF supper meal to the board when the cook writes the lunch menu? -Can you send out the monthly meal calendars to residents' rooms? *There were no emails documented for the months of September, October, or November. *The email communication from12/5/24 through 12/9/24 between activity director F and dietary director E stated: -From activity director F, "Still complaints on meals, food being too tough, or too many of the same things in a week or comes cold. I'm not sure where you guys want me to go with this". -From dietary director E, "I will check into this. Can you tell me what meals are cold? My menu's come from [supplier name]. The meat that have been tough is the pork." -Activity director F did not have the requested information. 11. Review of the provider's 1/9/25 admission agreement packet revealed: *"Residents are encouraged to participate in resident council. It is held monthly and provides discussion among the residents to communicate the group' wants and needs. It is led by the residents to empower them and give them a	F 585		

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F 585	Continued From page 22 voice for change." *"You have the right to voice grievances to the staff of Bethesda Home, or any other person, without fear of discrimination or reprisal. Bethesda Home must resolve the issue promptly." *The last page of the packet was a form labeled "BETHESDA HOME SUGGESTION OR CONCERN". -That form listed options of "suggestion" "concern/grievance" and "recognition". -That form included the following areas with space for documentation followed by space to identify who completed each section along with the date: --"Report of suggestion or concern." -"Investigation." -"Resolution." -"Follow up comments/Reviewed with concerned party." -The following statement was at the bottom of the form "Upon completion of the Suggestion or Concern form, please return the form to [provider's name] by mail or drop it off with the Social Services Director, Administrator or in the Front Office. Thank You." 12. Review of the November 2020 South Dakota State Long-Term Care Ombudsman Program resident rights handbook the provider included in their admission packet for newly admitted residents revealed residents have the right to raise concerns: *"Present grievances to staff or any other person, without fear of reprisal adn with prompt efforts by the facility to resolve those grievances and report the resolution." *"Discuss Care" *"Discuss Quality of Life."	F 585		

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F 585	Continued From page 23 13. Review of the provider's 1/8/24 Nutrition & Hydration policy revealed, the facility provided "Food and drink that accommodates resident allergies, intolerances and preferences." 14. Review of the provider's 10/1/17 Grievance Policy revealed: *A complaint was identified as "A verbal concern regarding resident care or services, which is resolved at the point of service; or A verbal concern that could have been addressed by staff present at the point of service if staff had been informed of the complaint at that time." *A grievance is identified as "A verbal complaint that cannot be resolved by the staff present, is postponed for later resolution, is referred to other staff for later" "A written complaint is always considered a grievance". *"Grievance Committee: An IDT (interdisciplinary team) committee designated by the governing body to Investigate, review and resolve resident grievances. This committee will be comprised of more than one person and may include the administrator, director of nursing, nurse manager, MDS (minimum data set) coordinator, social worker, activities director, dietary manager, laundry/housekeeping manager, maintenance manager, and/or the business manager." *"For concerns that cannot be promptly resolved, or that for other reasons are considered grievances rather than complaints, Bethesda will review, investigate, and respond to the patient/resident/representative in a manner compliant with its grievance policy." *"A complaint is considered resolved when a resident or their representative is satisfied with the actions taken on their behalf. A complaint that is unresolved shall be handled as a	F 585		

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F 585	Continued From page 24 grievance." *"On average, an appropriate time frame of response will be 7 business days." *"There may be situations where Bethesda has taken appropriate and reasonable actions on the resident's behalf in order to resolve the resident's grievance and the resident or their representative remains unsatisfied with Bethesda's actions. In these situations, Bethesda may consider the grievance closed for the purpose of satisfying CMS [Center's for Medicare and Medicaid Services] regulation."	F 585		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to maintain the physical, mental, and psychosocial wellbeing by ensuring staff promptly respond to call lights for five of five residents (2, 10, 17, 32, and 35) who used call lights to alert staff of their assistance needs. Findings include: 1. Interview on 1/7/25 at 9:03 a.m. with resident 35 revealed: *She stated she had to wait "too long" for her call	F 684	Immediate verbal and huddle education was provided to scheduled CNA, Nursing, Housekeeping, and Office staff to improve call light wait times for residents identified as #2, 10, 17, 32, and 35 on 1-8-25 and 1-9-25. Intentional resident rounding interviews and audits will be completed to determine resident satisfaction with call light response times to identify any other affected residents. Administrator or designee will assign and complete intentional resident rounding/ Angel round audits weekly for 4 weeks and monthly for 3 months. Facility call light policy has been reviewed and revised by the IDT and approved by the Medical Director on 1/31/2025. All licensed and unlicensed staff were provided with education regarding their responsibilities to ensure timely call light response times for the residents. Audits of resident call lights will be initiated weekly for 4 weeks and monthly for 3 months. Progress toward the reduction of call light wait time goals will be taken to QAPI monthly until the facility demonstrates sustained compliance as determined by the committee.	2/7/2025

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F 684	Continued From page 25 light to be answered. -It took up to 45 minutes for the call light to be answered, "usually it was one-half hour", and seldom was it 15 minutes or less. -The wait time was "especially" worse in the mornings. *She needed help to get dressed and undressed. -She did not need assistance to use the bathroom. 2. Interview on 1/7/25 at 9:09 a.m. with resident 17 revealed he: *Needed assistance in the mornings to dress. -Would use call light to notify staff when he wanted to get dressed. -Stated he "had to wait for them" to help him get dressed in the mornings. --His care conference was scheduled for that day (1/7/25) in the afternoon, and he was going to discuss this issue. 3. Interview and review of call light logs on 1/9/25 at 9:36 a.m. and again at 1:28 p.m. with MDS coordinator C revealed: *She was unable to print the call light logs. -She was "kind of surprised" how long some of the call light wait times were. *The facility was currently in a COVID-19 outbreak. -There were four residents currently COVID-19 positive. -She thought this might have contributed to the call light wait times. *Staff had forgotten to shut of a residents call light after they had provided the resident's care. 4. Review of resident 2's call light log revealed: *From 11/1/24 through 12/31/24 she waited after activating her call light was:	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	129 W HWY 12 WEBSTER, SD 57274

(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 684	Continued From page 26 -From 15 minutes to 29 minutes 43 times. -From 30 minutes to 44 minutes 15 times. -From 45 minutes to 59 minutes 3 times. -Over 59 minutes twice. *From 1/2/25 through 1/9/25 the time she waited after activating her call light was: -On 1/2/23 at 12:33 p.m. she waited 45:03 minutes. -On 1/4/25 at 7:30 a.m. she waited 32:22 minutes. -On 1/4/25 at 12:53 p.m. she waited 18:14 minutes. -On 1/6/25 at 7:43 a.m. she waited 39:22 minutes. -On 1/6/25 at 8:39 a.m. she waited 22:21 minutes. -On 1/6/25 at 9:27 a.m. she waited 26:04 minutes. -On 1/7/25 at 7:17 a.m. she waited 24:45 minutes. -On 1/8/25 at 7:22 p.m. 28:40 minutes. 5. Review of resident 32's call light log revealed: *From 11/1/24 through 12/31/24 the time she waited, after activating her call light, more than 30 minutes was three. *From 1/2/25 through 1/9/25 the time she waited after activating her call light was: -On 1/5/25 at 8:19 a.m. she waited 25:22 minutes. -On 1/8/25 at 8:29 a.m. she waited 16:12 minutes. *November and December 2024 were not reviewed. 6. Review of resident 35's call light logs revealed: *From 11/1/24 through 12/31/24 the time she waited, after activating her call light, more than 30 minutes was six times.	F 684		

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	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	129 W HWY 12 WEBSTER, SD 57274

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F 684	Continued From page 27 *From 1/2/25 through 1/9/25 the time she waited after activating her call light was: -On 1/4/25 at 4:41 p.m. she waited 15:38 minutes. -On 1/6/25 at 7:33 a.m. she waited 30:12 minutes. -On 1/7/25 at 7:25 a.m. she waited 24:55 minutes. -On 1/8/25 at 7:34 a.m. she waited 16:30 minutes. 7. Review of resident 10's call light log revealed: *November 2024 and December 2024 were not reviewed. *From 1/2/25 through 1/9/25 the time she waited after activating her call light was: -On 1/3/25 at 10:35 a.m. she waited 15;55 minutes. -On 1/6/25 at 11:13 a.m. she waited 22:50 minutes. -On 1/7/25 at 10:08 a.m. she waited 15:45 minutes. 8. Review of resident 17's call light log revealed: *November 2024 and December 2024 were not reviewed. *From 1/2/25 through 1/9/25 the time he waited after activating his call light was: -On 1/5/25 at 8:19 a.m. she waited 25:22 minutes. -On 1/8/25 at 8:29 a.m. she waited 16:12 minutes. 9. Interview and review of call light log wait times on 1/09/25 at 2:04 p.m. with DON B revealed: *When a resident expressed a complaint regarding their call light wait time she would "look at that". *They had "set assignments" for staff members to	F 684		

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	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

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BETHESDA HOME	129 W HWY 12 WEBSTER, SD 57274

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F 684	Continued From page 28	F 684		

if there was a concern, they would be able to determine who had provided care for the resident on that day.
*She had not received any reports of long call light wait times.
*There were no audits completed on residents call light wait times.
*She was not able to "speak specifically" regarding the long call wait times recorded in November and December 2024, and January 2025.
-She stated the "wait times [reviewed] are unacceptable."
1. Review of call light times for resident 1 from 1/2/25m through 1/9/25 revealed the following extended call light times:
-On 1/2/25 at 12:33 p.m., she waited 45:03 (minutes:seconds).
-On 1/4/25 at 7:30 a.m., she waited 32:22.
-On 1/4/25 at 12:53 p.m., she waited 18:14.
-On 1/6/25 at 7:43 a.m., she waited 39:22.
-On 1/6/25 at 8:39 a.m., she waited 22:21.
-On 1/6/25 at 9:27 a.m., she waited 26:04.
-On 1/7/25 at 7:17 a.m., she waited 24:45.
-On 1/8/25 at 7:22 p.m., she waited 28:40.

2. Interview on 1/9/25 at 11:25 a.m. with resident (2) revealed:
*Sometimes the call lights take a long time to answer.
*"They are busy."
*"I have had an [incontinence] accident sometimes."
*She said when she needs to pass urine or stool, "I don't have much time."
*When she has an accident, she is cleaned up right away.

3. Interview on 1/9/25 at 10:41 a.m. with licensed

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	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	129 W HWY 12 WEBSTER, SD 57274

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F 684	Continued From page 29 practical nurse (LPN) M and registered nurse (RN) I revealed: *Both agreed call lights should be answered as soon as possible. *Both agreed five minutes was a reasonable goal to answer call lights. *Both agreed the maximum time for a call light to be answered was 15 minutes. 4. Interview on 1/9/25 at 1:20 p.m. with director of nursing (DON) A revealed: *Call lights should be answered as soon as possible. *She said call lights can be answered by all staff. *There is not a specified time for when call lights should be answered. *Five minutes would be a reasonable time for a call light to be answered, but there were busy times when it could take longer than five minutes. 5. Review of the providers 1/2024 Call Light Policy revealed: *Purpose A. To ensure resident always has a method of calling for assistance. *B. To promptly answer the resident's call light. *Procedure, B. When resident's call light is observed/heard, go to the resident's room promptly. *C. Respond to request as soon as possible. Turn call light off and inquire about resident's request. *D. When leaving the room, place call light within easy reach of resident. 1. Interview on 1/7/25 at 9:07 a.m. with resident 21 revealed: *She stated she had turned on her call light and staff did not come to help her. *She did not receive help getting dressed that morning.	F 684		

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	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 30 2. Interview on 1/7/25 at 4:08 p.m. with resident 10 revealed: *She felt staff were slow to respond to her light. *She understood she was not the only resident who needed assistance with their cares. *She tried to ask for assistance at times when she felt the CNAs were less busy such as mid-morning or mid-afternoon. 3. Resident group interview on 1/8/25 at 1:25 p.m. revealed: *Resident 32 stated: -She had her call light on for over one hour before staff had responded. -While she waited for the staff to answer her call light, she was incontinent of urine. -When she was incontinent, she "soaked" her clothing and her bedding. *Resident 10 stated that she had been incontinent of stool while she waited for her call light to be answered. 4. Review of a 7/5/24 grievances filed by licensed social worker (LSW) H revealed: *On 7/5/24 at 10:00 a.m. LSW H was notified that resident 16 had a concern about her care. *LSW H was made aware of this concern by a written note from a CNA to the DON. *The note indicated on 7/3/24 at 8:00 p.m. resident 16 stated she was left on the commode for two hours. *Staff present at that time were interviewed and stated resident 16 was "upset because she was left on the commode without a call light." *On 7/5/24 when LSW H followed up with resident 16 she could not give specific information. *LSW H noted in her follow-up that resident 16	F 684		

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	435071	A. BUILDING _____ B. WING _____	C 01/09/2025

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F 684	Continued From page 31 was "more confused" and was "easily distracted". 5. Review of a 11/5/24 grievance filed by LSW H revealed: *Resident 27 reported to LSW H that she had pressed her call button at about 5:30 a.m. *She felt "flushed" and wanted a nurse to evaluate her. *Certified nursing assistant (CNA) K answered the call light. *CNA K told resident 27 to "wait for the day shift to address her concerns". *The director of nursing (DON) addressed the resident concerns with CNA K and re-educated her on responding to call lights promptly. 6. Review of the provider's 11/27/24 Facility Assessment revealed: *The provider "has a blended staffing model to promote resident quality of life and promote a home-like atmosphere." *"Staff assignments for coordination and continuity of care for residents within and across the three wings is determined in conjunction from the DON, Nurse Manager, RN, Licensed Nursing Staff, and DON/scheduler." The facility resident census report from 1/2/25 through 1/9/25 indicated there were 44 residents.	F 684		

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

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	435071	A. BUILDING _____ B. WING _____	01/07/2025

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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 1/7/25. Bethesda Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Cunningham
TITLE: Administrator
(X6) DATE: 1-31-25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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
	435071	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	**129 W HWY 12** **WEBSTER, SD 57274**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 1/7/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethesda Home was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Melissa Cunningham

TITLE
Administrator

(X6) DATE
1-31-25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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
	10706	A. BUILDING: _____ B. WING _____	01/09/2025

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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 1/7/25 through 1/9/25. Bethesda Home was found in complaince.	S 000		
S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/7/25 through 1/9/25. Bethesda Home was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Cunningham

TITLE: Administrator

(X6) DATE: 1-31-25