STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	**1001 S EGAN AVE , MADISON, South Dakota, 57042**

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F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/8/26 through 9/10/26. Bethel Lutheran Home was found not in compliance with the following requirements: F554, F561, F689, F695, F697, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/8/26 through 9/10/26. Areas surveyed included allegations of potential resident-to-resident abuse and medication security related to a missing medication. Bethel Lutheran Home was found not in compliance with the following requirements: F600, F609, F689, and F755.	F0000		
F0561 SS = G	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in	F0561	1. Resident #22 was assessed immediately regarding concerns related to dietary choices, dialysis compliance, emotional well-being, and statements regarding self-harm. The attending physician, mental health provider, registered dietitian, and responsible party were notified. Resident #22 was educated regarding her physician-ordered regular diet, dialysis recommendations, risks and benefits of treatment choices, and her right to make informed decisions regarding food preferences and medical treatment. The resident's dietary card was immediately corrected to reflect the physician-ordered regular diet. The unauthorized renal diet designation and fluid restriction implemented without a physician order were removed. An interdisciplinary care plan review was completed to address dietary preferences, resident choice, dialysis-related education, communication processes, and psychosocial needs. Staff involved received immediate counseling regarding resident rights, resident choice, and implementation of dietary modifications only with appropriate physician orders.	October 6, 2026

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F0561 SS = G	Continued from page 1 community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to protect the residents' right to make choices for one of one sampled resident (22) with physician-ordered regular diet and dialysis treatments (a treatment that removes waste products and excess fluids from blood when the kidneys are unable to), who was not offered the opportunity by the facility staff to choose what she wanted to eat, expressed that she was upset by not being allowed to make those choices, and because she was not allowed to, she wanted to refuse dialysis treatments and had thoughts of self-harm. Findings include: 1. Interview on 9/8/26 at 9:38 a.m. with resident 22 in her room revealed that she went to dialysis treatments three times a week but did not attend her dialysis treatment on 9/7/26 because she was thinking about not continuing her dialysis treatments. She stated her dialysis treatments took three hours each time and wore her out, and because of that, she felt like she missed out on things that were happening at the facility, like bingo and other activities that she enjoyed. She did not feel well and was nauseated that day (9/8/26). She was angry that the facility staff changed her diet and put her on a fluid restriction. She said she was "fed up with it," and that the facility changed her diet frequently without telling her, and she could not eat the foods that she wanted. 2. Review of resident 22's electronic medical record (EMR) revealed she admitted to the facility on 5/14/26. Her diagnoses included end-stage renal disease (the final, irreversible fifth stage of chronic kidney disease where the kidneys can no longer support the body's needs), type 2 diabetes mellitus (a condition involving disruptions in how the body regulates blood sugar), abnormal weight loss,	F0561	2. The Director of Nursing (DON), Registered Dietitian, and Dietary Manager completed an audit of all current residents receiving therapeutic diets, fluid restrictions, dialysis services, and other medically related dietary interventions to ensure dietary services accurately reflected current physician orders. A 100% audit was conducted of all dietary cards, tray tickets, fluid restrictions, and diet communication tools utilized by nursing and dietary staff to verify consistency with physician orders and resident preferences. Any discrepancies identified were immediately corrected. A 100% audit was also completed for residents receiving dialysis treatments to ensure resident rights related to informed choice and participation in care planning were appropriately documented.	

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F0561 SS = G	Continued from page 2 gastroesophageal reflux disease without esophagitis (chronic acid reflux symptoms, but no signs of physical damage), recurrent depressive disorders (disorders that cause persistent feelings of sadness, emptiness, and a loss of interest in activities), borderline personality disorder (a mental health condition that causes intense mood swings, unstable relationships, and a troubled sense of self), and suicidal ideation (thinking about, considering, or planning the act of intentionally causing one's own death). Her 8/18/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 5/14/26 physician's order for a regular diet. 3. Observation on 9/8/26 at 11:23 a.m. of the meal service in the dining room revealed that resident 22 walked into the dining room with her cane. The staff offered most residents a choice of two meals that day. At 11:51 a.m., administrative assistant NN served resident 22 a meal of chicken, beans, and mashed potatoes with no gravy. Administrative assistant NN stated, "This is what you can have," as she placed the plated meal in front of resident 22. Resident 22 rolled her eyes, sighed, and appeared upset but did not respond. Dietary aide (DA) OO offered most residents in the dining room a choice of a chocolate brownie or peaches for dessert. The two residents seated at the table with resident 22 chose a brownie for their dessert. Resident 22 asked DA OO, "What can I have?" Resident 22's tone and body language displayed that she appeared frustrated. DA OO stated that she did not know which dessert resident 22 could have and went to the service line and asked dietary manager (DM) T about that. DM T said, "Peaches," and "She [resident 22] will roll her eyes." DA OO returned to resident 22's table and said to her, "Peaches, is that okay?" and handed resident 22 a cup of peaches. Resident 22 appeared frustrated, shook her head, and did not verbally respond to that question. 4. Interview on 9/8/26 at 3:32 p.m. with resident 22 in her room revealed she did not have a choice of food at the lunch meal that day. She explained that she wanted the meal option of cabbage and bacon that was offered that day, but she was not offered a choice, and the staff served her the meal she was	F0561	3. The facility implemented the following systemic changes: • Revised the communication process between dialysis providers, nursing, and dietary departments to clarify that recommendations from outside providers will not be implemented without physician review and appropriate orders when required. • Implemented a verification process requiring the Dietary Manager or designee to validate all diet changes against current physician orders before updating dietary cards, tray tickets, or meal service instructions. • Educated all nursing, dietary, social services, and leadership staff regarding: F561 Resident Rights and Self-Determination. Residents' rights to make informed choices regarding meals, treatment, and quality of life. Physician order verification requirements. Resident-centered care planning and informed consent. Documentation and communication expectations. • Implemented a resident choice review during care plan meetings for residents receiving therapeutic diets, fluid restrictions, dialysis services, or other specialized nutritional interventions. • Established a process requiring immediate interdisciplinary review whenever a resident expresses concerns regarding dietary restrictions, treatment refusal, quality of life, or psychosocial distress.	

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=0561 SS = G	Continued from page 3 allowed to eat. She wanted a brownie like the other residents had, but she had to have peaches. She felt she did not have a choice at meals, and the staff told her it was because of her ordered diet. She did not know who made the decisions about her diet but thought that she had to have a certain diet because she received dialysis treatments, so she wanted to quit dialysis treatments. She did not talk to the doctor since her diet was last changed, which she thought was a couple of days ago. She did not think anyone at the facility had asked her what her meal preferences were, because she was told by the staff which foods she could and could not eat. She was on a renal diet (a specialized eating plan to protect kidney function) when she started dialysis treatments, and the dialysis center provided her with a list of foods that she could have. She thought that the physician had taken her off the renal diet before she admitted to the facility. The kitchen staff members told her the physician put her back on the renal diet again, but she wanted to be on a regular diet. Resident 22 stated that because she did not have choices about what she ate, and staff members told her she could not have foods that she wanted, she wanted to die. She wanted to stop her dialysis treatments to hurt herself. She had not told anyone else she felt that way. The surveyor immediately explained to resident 22 that a nurse needed to be notified of how she felt. She stated that she understood, and director of nursing (DON) B was notified and entered her room to speak to her. The surveyor exited the room. 5. Observation, interview, and record review on 9/10/26 at 12:07 p.m. with resident 22 in the common area outside of the dining room revealed that resident 22 stated she was frustrated because she was told by the dietary staff that she was on a renal diet and was not provided a choice of meals at breakfast or lunch that day (9/10/26) or allowed to have mashed potatoes and gravy or ice cream for supper last night (on 9/9/26). She was told by the staff at the hospital and at her dialysis treatment yesterday (on 9/9/26) that she was on a regular diet and could eat what she wanted to. She said she wanted milk with her oatmeal, mashed potatoes, and the same	F0561	4. The DON, Administrator, Registered Dietitian, Dietary Manager, or designee will conduct audits of: • Five residents receiving therapeutic diets or fluid restrictions weekly for four weeks. • Five residents monthly for two additional months. • Verification that dietary cards, tray tickets, and meal service instructions match physician orders. • Documentation that residents are offered choices within their prescribed diets and are educated regarding risks and benefits when choosing alternatives. • Evidence that resident preferences are incorporated into care planning. • Documentation of interdisciplinary follow-up for treatment refusals or quality-of-life concerns. The DON/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0561 SS = G	Continued from page 4 desserts as the other residents. She took her 9/9/26 hospital discharge papers out of a manila envelope in her walker basket and stated, "This says I am on a regular diet." She said she wanted a choice about what she ate and was frustrated that she was told "different things by different people." 6. Interview and record review on 9/10/26 at 12:23 p.m. with DA OO and DM T revealed that DA OO thought that resident 22 was on a renal diet and that the cook decided which food items resident 22 was allowed to eat at each meal. DM T thought resident 22 was on a renal diet because she updated resident 22's dietary card (a laminated index card the dietary staff used when they served the residents meals, to know which diet the resident was on and any resident food preferences), which changed back to a renal diet last week. DM T provided the surveyor a handwritten note dated 9/7/26 that hung in the kitchen on the left side of the food serving table that indicated resident 22 was "on a renal diet." DM T confirmed that resident 22's dietary card indicated she was on a renal diet. DA OO and DM T thought resident 22 was offered a choice of which foods she wanted when there was more than one food item to choose from on the renal diet menu plan offered that day. DM T said the dietary staff was "diligent" in providing the residents' their physician-ordered diets. 7. Review of resident 22's dietary card revealed that it indicated on 9/6/26 she was on a "renal diet" with regular portion sizes and that dietary staff was to serve her half "of all normal [amount of] liquids..." 8. Review of the 9/7/26 handwritten note revealed "[resident 22 was] on [a] renal diet and [to] cut [the] amount of fluids [she received] at meals in half. Do this until Wednesday when [she] has dialysis (due to skipping Dialysis). Thanks! [registered nurse (RN) PP] ([name redacted] Dialysis[center clinical care leader (CCL) RN Y]." 9. Interview and record review on 9/10/26 at 12:34 p.m. with director of nursing (DON) B revealed that resident 22 returned to the facility from the hospital on 9/9/26 with no change to the resident's 5/14/26 physician order for a regular diet. She was unaware that resident 22 was receiving a renal diet, was told	F0561		

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F0561 SS = G	Continued from page 5 that she could not have mashed potatoes with gravy, milk, or ice cream, and was not offered to choose the foods she wanted to eat. DON B was unaware of the handwritten note that indicated resident 22 was on a renal diet. 10. Interview on 9/10/26 at 12:48 p.m. with DON B, RN J, registered dietitian (RD) W, and RN PP, who participated by phone, revealed that on 9/7/26 it was reported to RN PP by RN J that resident 22 refused to go to dialysis that day (9/7/26) and that dialysis center CCL RN Y recommended putting resident 22 on "limit fluid [fluid restriction]" and a renal diet. RN J said that dialysis center CCL RN Y knew resident 22 was happy to get off the renal diet and thought that putting her back on a renal diet would encourage her to go to her dialysis treatment that day (9/7/26). Resident 22 did not go to her dialysis treatment on 9/7/26, and RN PP felt it was important that the kitchen staff knew dialysis center CCL RN Y's dietary recommendations, so she provided them with the handwritten note that was dated (9/7/26). RD W stated that it was important for resident 22 to understand how not going to dialysis would affect her body, and that the dietary recommendations were appropriate for her. Resident 22 should have been educated about the renal diet and then offered a choice about resuming a renal diet with a fluid restriction or eating what she wanted. DON B stated there was no change to resident 22's 5/14/26 physician-ordered regular diet and that, even if she was on a physician-ordered renal diet, resident 22 should have been educated about dialysis center CCL RN's recommendations and allowed to make her own choices about what she ate. 11. Phone interview on 9/10/26 at 2:08 p.m. with dialysis center CCL RN Y revealed that on 9/7/26 resident 22 refused to attend her scheduled dialysis treatment, and it was dialysis center CCL RN Y's recommendation that resident 22 resume a renal diet and a fluid restriction to limit complications that could occur because of resident 22's refusal to attend dialysis. Her recommendation was not a physician's order. Resident 22 was on a physician-ordered regular diet and should have been educated about dialysis CCL RN Y's recommendation, but resident 22 was able to make her own choices.	F0561		

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=0561 SS = G	Continued from page 6 12. Review of the provider's undated Skilled Nursing Facility - Resident Bill of Rights policy revealed "Nursing facilities must protect and promote each resident's right to dignity, [and] self-determination... regardless of diagnosis," and the residents "Be treated with respect and dignity; receive care in a manner and environment that maintain or enhance quality of life and recognize individuality and preferences (daily schedule...meals...)." Residents have the right to "make choices about significant aspects of life in the facility."	F0561	1. Resident #6 was assessed by nursing, hospice, and the attending physician regarding ongoing complaints of pain, pain-related behaviors, and effectiveness of current pain management interventions. An interdisciplinary review of Resident #6's pain management plan was completed. Hospice services, the attending physician, nursing, and family were notified of concerns regarding uncontrolled pain. The resident's pain medications, frequency of administration, effectiveness, and non-pharmacological interventions were evaluated and revised as clinically indicated. Resident #6 was reassessed for pain, including verbal and non-verbal indicators, and interventions were implemented to address her pain in accordance with hospice recommendations, physician orders, resident goals, and preferences. The resident's care plan was updated to reflect: • Hospice status. • Left tibia fracture. • Individualized pain indicators. • Non-verbal expressions of pain. • Pharmacological and non-pharmacological interventions. • Monitoring requirements. • Desired pain management outcomes. Staff involved in the resident's care received immediate counseling regarding recognition of pain, assessment requirements, timely intervention, hospice collaboration, and reassessment of effectiveness.	October 6, 2026
=0697 SS = G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to recognize and adequately manage pain for one of two sampled hospice residents (6) who reported having pain. Findings include: 1. Observation on 9/8/26 at 11:14 a.m. in the dining room revealed that when certified nursing assistant (CNA) L wheeled resident 6 to the dining room table, resident 6's left foot hit the table leg. Resident 6 began to shout that she was in pain. The staff tried to redirect the resident and get her to eat, but she said that she was not hungry and repeatedly said that she was in pain. The staff assisted resident 6 back to her room. 2. Interview on 9/8/26 at 2:42 p.m. with resident 6 in her room revealed that she was lying in her bed since being brought back from her noon meal. She stated that she hit her big toe on the table at lunchtime. She said that it really hurt, and it still hurts. She reported that the staff did not try to manage her pain. 3. A review of resident 6's electronic medical record (EMR) revealed her medical diagnoses included weakness, bipolar disorder (a mental health	F0697		

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=0697 SS = G	Continued from page 7 condition that causes extreme shifts in mood, energy, activity levels, and the ability to concentrate), and fracture of the of upper end of the left tibia (shin bone). she was admitted to the facility on 6/18/21. Her 8/17/26, Brief Interview for Mental Status (BIMS) score was 11, which indicated her cognition was moderately impaired. She sustained a left tibia fracture on 8/27/26 due to an unwitnessed fall. After family declined surgical intervention for the tibia fracture, she admitted on hospice on 9/1/26. Resident 6's 11/3/23 physician orders indicated that she received scheduled Tylenol (a mild pain reliever) three times per day. There was a 8/31/26 physician's order for Oxycodone 5 mg (opioid pain medication used to treat severe pain) to be administered every four hour as needed (PRN). There was a 9/1/26 physician's order for liquid Morphine 5 mg liquid (opioid pain medication used to treat severe pain that cannot be managed by other treatments) to be administered every two hours PRN. Resident 6's care plan (personalized plan that addresses a resident's care needs, goal, and interventions) indicated that it was not updated after her tibia fracture or her admission to hospice. On 9/29/21, the staff indicated "Resident 6 is at risk for uncontrolled pain r/t [related to] osteoarthritis." Interventions included "Administer analgesia [pain relief] as per orders. Give ½ hour before treatment or care PRN. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Evaluate the effectiveness of pain interventions after administration." On 9/8/26, resident 6 did not receive any of her PRN oxycodone and there were no pain ratings documented that day. On 9/9/26, resident 6's pain was documented as an 8/ out of 10 (using the 10-point pain scale), and oxycodone was administered by RN J. Resident 6 did not receive any morphine at this time. On 9/10/26 at 6:50 a.m., resident 6's pain was documented as a 6 out of/10 and she received oxycodone. At 9:19 a.m. her pain was documented as a 5 out of/10 and she received morphine for the first time since her admission to hospice. 4. Observation on 9/9/26 at 12:27 p.m. outside of resident 6's room revealed, she could be heard shouting "My big toe, it hurts." from inside her room and into the hallway. She shouted that sentence four times. When a staff member entered her room and asked what toe was hurting, she replied "the left."	F0697	2. The Director of Nursing (DON)/designee, and licensed nursing staff completed a 100% audit of all residents who: • Receive hospice services. • Have diagnoses associated with acute or chronic pain. • Receive scheduled or PRN pain medications. • Have experienced a recent injury, fracture, surgery, or significant change in condition. • Demonstrate verbal or non-verbal indicators of pain. The audit included review of: • Pain assessments and reassessments. • Hospice recommendations. • Physician notifications. • Medication administration records. • Response to identified pain. • Care plans. • Documentation of effectiveness of interventions. Any concerns identified during the audit were immediately addressed through reassessment, physician notification, hospice consultation, medication review, and care plan revision.	

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F0697 SS = G	Continued from page 8 5. Observation on 9/9/26 at 4:14 p.m. outside of resident 6's room revealed that resident 6 could be heard from inside her room and into the hallway shouting "owww, owww, owww." CNA FF went into resident 6's room to check on the resident. CNA FF then told contracted travel registered nurse (RN) Z that resident 6 had complained of pain. Contracted travel RN Z went into resident 6's room and told her "I'll be back in 10 minutes. I'm going to set an alarm on my phone." At 4:25 p.m., resident 6 could be heard shouting "let me die, let me die, let me die." At 4:26 p.m., resident 6 is heard shouting "Please dear god, if you can hear me, I can't take it anymore." At 4:27 p.m., contracted travel RN Z was in resident 6's room and was heard saying "How's the ice? Is it making the pain better? I'll bring your pain medicine in a few minutes." At 4:31 p.m., Minimum Data Set (MDS)/RN E walked into resident 6's room, and the resident was moaning in pain. At 4:34 p.m., resident 6 was heard shouting "owwww, owwww, owwww." At 4:35 p.m., contracted travel RN Z administered 1 milligram (mg) of Lorazepam (a controlled medication used to treat anxiety) to resident 6. 6. Observation and EMR review on 9/10/26 at 7:12 a.m., outside of resident 6's room revealed resident 6 could be heard shouting "owww" repeatedly from inside her room and into the hallway. Her EMR indicated that she received 5 mg of Oxycodone for pain and 0.5 mg of Lorazepam for anxiety and restlessness at 6:50 a.m. on 9/10/26. 7. Interview on 9/10/26 at 7:40 a.m. with CNA L revealed that she recalled bumping resident 6's leg in the dining room on 9/8/26. She reported that she did not tell the nurse about the event. 8. Observation and interview on 9/10/26 at 9:05 a.m with resident 6 and RN J revealed that resident 6 could be heard shouting from inside her room and into the hallway, "Ow, hurts very bad." RN J stood at the medication cart outside resident 6's door, preparing to administer resident 6's nebulizer (a device that converts liquid medication into an inhalable mist) treatment. The surveyor entered resident 6's room. Resident 6 appeared distraught and repeated, "Ow," "hurts very bad," "nurse," and "I can't stand it." Resident 6 indicated that she was in pain and stated the pain was in her "left ankle." RN J entered resident 6's room, administered the	F0697	3. The facility implemented the following systemic changes: · Re-educated all licensed nurses, certified nursing assistants, medication aides, agency staff, contract staff, and leadership regarding: o F697 Pain Management requirements. o Recognition of verbal and non-verbal indicators of pain. o Pain assessment and reassessment standards. o Hospice resident pain management. o Timely intervention and physician notification. o Documentation of pain, interventions, and effectiveness. o Resident-centered pain management goals. o Differentiating behavioral symptoms from potential expressions of pain. · Implemented a standardized pain assessment process requiring nursing evaluation whenever: o A resident reports pain. o Staff observe verbal or non-verbal indicators of pain. o A resident experiences injury or trauma. o A significant change in condition occurs. o Pain management interventions are ineffective. · Implemented a hospice pain management review process requiring collaboration with hospice and the attending physician when residents continue to demonstrate signs of uncontrolled pain. · Revised care planning processes to ensure care plans are updated following: o Hospice admission. o New injuries or fractures. o Significant changes in pain status. o Changes in medication regimens. o Persistent indicators of pain. · Reinforced staff expectations that resident complaints, grimacing, moaning, yelling, restlessness, and other individualized pain indicators are assessed and addressed promptly rather than attributed solely to psychiatric diagnoses, behavioral conditions, or historical behaviors.	

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=0697 3S = G	Continued from page 9 nebulizer treatment by securing a mask containing the medication to resident 6's face, and stated that resident 6 had already received pain medication and was safe to complete the nebulizer treatment herself. Resident 6 continued to shout "Ow," and "hurts very bad," while she received the nebulizer treatment. 9. Observation on 9/10/26 at 9:21 a.m., outside of resident 6's room revealed resident 6 could be heard from inside her room and into the hallway shouting "owww, owww, help me, help me, help me." 10.Interview on 9/10/26 at 9:32 a.m. with RN J revealed that she reported that resident 6 "yelled out" before she had broken her ankle. 11. Interview on 9/10/26 at 9:42 a.m., resident 6 in her room revealed that resident 6 stated that her leg hurts. Her face was grimacing. When asked to rate her pain on a 0 to10 pain scale, she did not give a number. She said "It's the worst." 12. Interview on 9/10/26 at 1:02 p.m. with licensed practical nurse (LPN) K revealed that he did not feel resident 6's pain was being adequately managed. "After hearing her this morning, I think we need to re-evaluate how we are treating her pain. Between nursing, management, and hospice, we need to get on the same page." He reported that before her leg injury, she would have behaviors related to her bipolar disorder, but the behaviors were not about her pain. 13. Interview on 9/10/26 at 1:13 p.m. with RN J revealed that she felt that resident 6's pain was being adequately controlled. In reference to resident 6's shouting, she said "She [resident 6] is also bipolar. She had these behaviors before the leg fracture. We are trying to get to a happy medium, where her pain is controlled, but she can still enjoy her day." RN J reported that when she gave resident 6 her oxycodone earlier in the morning, it controlled her pain. 14. Phone interview on 9/12/26 at 2:15 p.m. with the resident 6's family member revealed that he felt that resident 6 had a very low threshold for pain. He felt that if she was saying that she was in pain, then she was experiencing pain. 15. Observation on 9/10/26 at 4:25 p.m. with MDS/RN E revealed that when she heard resident 6 screaming in her room, she walked away and said,	F0697	4. The DON or designee will conduct the following audits: Pain Management Audits • Weekly audits of five residents receiving pain medication, hospice services, or treatment for painful conditions for four weeks. • Monthly audits of five residents for two additional months. Audits will verify: • Completion of pain assessments and reassessments. • Timely response to reported or observed pain. • Appropriate implementation of interventions. • Documentation of effectiveness. • Hospice and physician involvement when indicated. • Compliance with physician orders and resident preferences. Care Plan Audits • Weekly audits of residents with identified pain concerns for four weeks. • Monthly audits for two additional months. Audits will verify care plans accurately reflect current pain management needs, interventions, and goals. Hospice Resident Audits • Weekly review of all hospice residents for four weeks. • Monthly review for two additional months. Audits will verify pain control measures are individualized, documented, and effective. The DON/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0697 SS = G	Continued from page 10 "That's her usual yelling." 16. Interview on 9/10/26 at 4:30 p.m. with director of nursing (DON) B revealed that she was aware of resident 6's shouting. She indicated that resident 6 had a long history of behavioral issues related to her bipolar disorder. She reported that when she went into resident 6's room on the afternoon of 9/9/26, the resident was complaining that it was her hand that hurt. DON B was not aware that resident 6's left leg had bumped the dining room table on 9/8/26 and was not aware that the resident had indicated to the surveyors and the staff that it was her left leg that was hurting. 17. Review of the provider's 5/2025 Pain Assessment and Management Policy and procedure revealed "2. 'Pain management' is defined as the process of alleviating the resident's plan [pain] to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary care process that includes the following: a. Assessing the potential pain. B. Effectively recognizing the presence of pain. C. Identifying the characteristics of pain. D. Addressing the underlying causes of pain. G. Monitoring for the effectiveness of interventions. H. Modifying approaches as necessary. 5. Conduct a comprehensive pain assessment, including the resident's acceptable level of pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain."	F0697	1. Because all residents received food prepared and stored through the facility kitchen, all residents had the potential to be affected by the deficient practice. Upon identification of the deficiency, the Dietary Manager and Administrator immediately initiated corrective actions related to refrigeration temperature monitoring and sanitizer solution testing. The walk-in refrigerator was evaluated, and a refrigeration service provider was contacted to diagnose and repair the malfunctioning cooling system. Food temperatures were assessed to ensure food safety standards were maintained. Any food items determined to be unsafe were discarded in accordance with food safety guidelines. The facility immediately implemented monitoring of the walk-in refrigerator using a calibrated internal thermometer and began documenting actual refrigerator temperatures and corrective actions for temperatures exceeding 41°F. The sanitizer bucket process was immediately corrected. Dietary staff tested sanitizer concentrations using approved test strips and documented sanitizer concentrations and bucket changes according to facility policy. Staff received immediate re-education regarding food safety requirements, temperature monitoring, sanitizer testing, and required documentation.	October 6, 2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F0812		

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=0812 SS = F	Continued from page 11 (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, documentation review, interview, and policy review, the provider failed to follow food safety and sanitation practices to ensure the staff maintained one of one walk-in refrigerator temperature at or below 41 degrees Fahrenheit (F) and monitored the chemical sanitation levels for one of one sampled red chemical sanitation bucket (a color-coded commercial container used in food service and kitchens to hold wiping cloths submerged in a chemical sanitizing solution) used to clean the main kitchen surfaces for the preparation of residents' food. Failure to ensure this increased the potential risk of foodborne illnesses for the entire resident population who received meals prepared in the main kitchen. Findings include: 1. Observation on 9/8/26 at 8:35 a.m. in the main kitchen revealed that the walk-in refrigerator's external digital thermometer read 43 degrees F. The temperature log attached to the walk-in refrigerator door indicated the refrigerator's temperatures ranged from 38 to 44 degrees F in September 2026. On eight days the temperatures were greater than 41 degrees. The walk-in refrigerator had several cardboard boxes stacked near the back. The surveyor could not locate the internal refrigerator thermometer. Boxes of ground meat were on the bottom shelf to the right of the door; fresh fruits and vegetables were on the middle shelves on the right side; and beverages and leftover foods were stored on the shelves to the left of the door. A red chemical sanitation bucket was on the counter near the sink. The posted Sanitizer Bucket Log appeared incomplete. 2. Review of the provider's May 2026 through September 2026 Refrigerator Temperature Log revealed that the temperatures were monitored twice daily once in the morning and once in the afternoon. There was a section titled "CORRECTIVE ACTION OF	F0812	2. Because meals prepared in the main kitchen are served to the entire resident population, all residents were identified as having the potential to be affected by the deficient practice. The Dietary Manager, Registered Dietitian, and Administrator completed a comprehensive review of: · Refrigerator and freezer temperature logs. · Food storage practices. · Food holding temperatures. · Sanitizer bucket logs. · Sanitizer testing procedures. · Kitchen sanitation practices. · Dietary department documentation systems. A review of all refrigeration units was conducted to ensure equipment functioned properly and maintained temperatures at or below required standards. Any identified concerns were corrected immediately. 3. The facility implemented the following systemic changes: Refrigeration Monitoring · All refrigeration units will be monitored using calibrated thermometers located within each unit. · Refrigerator temperatures will be documented at least twice daily. · Any temperature exceeding 41°F will require immediate documentation of corrective actions. · The Dietary Manager or designee will review temperature logs daily for compliance. · A maintenance notification process was established for any refrigeration equipment not maintaining required temperatures. Sanitizer Monitoring · Dietary staff will test sanitizer concentrations using approved test strips each time sanitizer buckets are filled and at least every four hours thereafter. · Sanitizer concentrations will be documented on the facility sanitizer log. · Sanitizer solutions will be changed according to policy and whenever visibly dirty. · The Dietary Manager will review sanitizer documentation daily.	

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F0812 SS = F	Continued from page 12 TEMPERATURES > [greater than] 41 [degrees] F." In May 2026, the temperatures were documented for 29 days. On 22 of those days, the temperature was 42 degrees F or higher, and no corrective actions were documented. In June 2026, the temperatures were documented for 31 days. On 27 of those days, the temperature was 42 degrees F or higher, and no corrective actions were documented. In July 2026, the temperatures were documented for 31 days. On 29 of those days, the temperature was 42 degrees F or higher, and no corrective actions were documented. In August 2026, the temperatures were documented for 31 days. On 29 of those days, the temperature was 42 degrees F or higher, and no corrective actions were documented. In September 2026, the temperatures were documented for 8 days. On 8 of those days, the temperature was 42 degrees F or higher, and no corrective actions were documented. 3. Observations and interview on 9/9/26 at 9:38 a.m. in the main kitchen with cook V and dietary manager (DM) T revealed that the walk-in refrigerator external thermometer read 42 degrees F. Cook V stated that she monitored the walk-in refrigerator temperature twice a day and documented the temperature displayed on the external thermometer. She did not monitor the temperature by using a thermometer inside the walk-in refrigerator. She looked for a thermometer inside the refrigerator and was unable to find one. She stated that the temperature needed to be below 45 degrees F and that, if it were over 45 degrees F, she would notify DM T or the maintenance department. DM T located a thermometer inside the walk-in refrigerator behind the cardboard boxes and stated it read "41ish degrees" F. When the surveyor observed the internal analog thermometer, it read 44 degrees F. DM T indicated that she felt the walk-in refrigerator's temperature increased because the walk-in refrigerator door was opened several times, and they were in the middle of the breakfast meal service. She expected the dietary staff to alert her if the walk-in refrigerator's external thermometer digital display read 45 degrees or higher.	F0812	3. continuted Staff Education All dietary staff, including cooks, dietary aides, supervisors, and newly hired staff, received education regarding: • F812 food safety requirements. • Proper refrigeration temperature standards. - Time and temperature control for safety (TCS) foods. • Documentation of corrective actions when temperatures exceed acceptable ranges. • Sanitizer testing procedures. • Sanitizer concentration requirements. • Food storage and sanitation practices. • Infection prevention and control related to food service operations. Management Oversight The Registered Dietitian and Dietary Manager revised kitchen auditing processes to include verification of refrigerator temperatures, temperature logs, sanitizer testing documentation, and corrective action compliance during routine dietary audits. 4. The Dietary Manager, Administrator, Registered Dietitian, or designee will complete monitoring as follows: Refrigeration Audits • Daily review of refrigerator temperature logs for four weeks. • Weekly refrigeration audits for eight additional weeks. • Verification that temperatures remain at or below 41°F. • Verification that corrective actions are documented and implemented when temperatures exceed acceptable ranges. with food storage, sanitation, temperature control, and documentation requirements.	

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=0812 3S = F	Continued from page 13 4. Interview on 9/9/26 at 11:08 a.m. with DM T regarding the walk-in refrigerator temperature revealed that she monitored the walk-in refrigerator internal analog thermometer daily to ensure the temperature was 41 degrees F or lower, but she did not document those temperatures. She believed the maintenance department knew the external digital thermometer was "off by a few degrees." She expected the dietary staff to monitor the external digital thermometer and report to her if the temperature was 45 degrees F or higher, because that would indicate the air temperature inside the walk-in refrigerator might be out of range. She stated that when the external digital thermometer displayed 44 degrees F, the internal analog thermometer read 41 degrees F. 5. Observation on 9/9/26 at 11:12 a.m. with cook V revealed the garden salad from the walk-in refrigerator was placed on an ice tray near the serving line. Cook V stated that the salad temperature was 46 degrees F and that it was safe to serve the residents because those vegetables could be served at room temperature. 6. Observation on 9/9/26 at 12:30 p.m. revealed the walk-in refrigerator external digital thermometer read 44 degrees F. The internal analog thermometer in the middle back of the refrigerator read 44 degrees F. The milk containers stored in the back right side of the walk-in refrigerator had temperatures, measured with the surveyor's thermometer, ranging from 41.9 to 44 degrees F, depending on how far back the milk jugs were located. The temperature between the one-pound blocks of butter was 42 to 45 degrees F. The internal temperature of a sampled container of cream cheese was 42 degrees F. When the thermometer was moved to the front left of the door, the temperature read 46 degrees F. 7. Review of the provider's "2026 Service log for SNF [skilled nursing facility] Walk-in Cooler" revealed that on 4/1/26 the evaporator coil (a series of metal tubing hidden inside the freezer or fridge compartment that absorbs heat from the interior to cool and chill the food) was frozen, and the service provider (name redacted) was "messaged." On 5/2/26, the thermostat was set at 45 (degrees F) and read 33 (degrees F); the evaporator coil was frozen, defrosted, and cleaned, and the (name redacted) service provider was messaged and	F0812	4. continued Sanitizer Audits • Daily review of sanitizer bucket logs for four weeks. • Weekly audits for eight additional weeks. • Verification that sanitizer concentrations are tested and documented according to policy. • Verification that sanitizer solutions are changed according to required schedules. Kitchen Sanitation Audits • Weekly kitchen sanitation observations for twelve weeks. • Verification of compliance with food storage, sanitation, temperature control, and documentation requirements. The Dietary Manager/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0812 SS = F	Continued from page 14 replaced the thermostat. On 5/3/26, the condenser unit (cooling system that releases heat absorbed from inside a refrigerator to the outside environment) was not running, and the (name redacted) service provider was messaged. On 5/4/26, (name redacted) service provider "worked on [the walk-in] Cooler. They said it was working again." On 7/27/26, the "[Walk-in] Cooler [was] not staying at set temperature. (Name redacted) replaced thermostat." 8. Review of the provider's 5/1/26 through 5/6/26 external contractor (name redacted) walk-in cooler invoice revealed "Walk-in cooler not working. Changed out bad pressure control and bad TXV [thermostatic expansion valve (a precision control device that regulates the amount of liquid refrigerant entering the evaporator)] + [and] filter drier [component in a refrigeration system that removes moisture and traps solid debris to protect internal parts]." 9. Interview and review of the walk-in temperature log on 9/10/26 at 7:07 a.m. with DM T revealed that a 9/9/26 refrigeration service call diagnosed an issue with the walk-in refrigerator's solenoid (an electrically operated switch that uses an electromagnetic coil to automatically open or close the flow of refrigerant or water inside a cooling system), and that DM T remained at the facility overnight to monitor the walk-in refrigerator's temperatures hourly to ensure that the temperature remained at 41 degrees F or lower. She expected that the "solenoid" would be replaced later that day (9/10/26). The walk-in refrigerator temperatures monitored from 9/9/26 at 3:20 p.m. through 9/10/26 at 7:00 a.m. recorded temperatures of 42 to 44 degrees F on 9/9/26 between 3:20 p.m. and 6:10 p.m., and the temperatures remained 41 degrees F or lower after 9/9/26 at 6:30 p.m. 10. Observation on 9/10/26 at 7:33 a.m. in the walk-in refrigerator revealed that the temperatures of two test glasses of milk in the walk-in refrigerator were 41 and 42 degrees F. 11. Interview on 9/10/26 at 9:43 a.m. with DM T and registered dietitian (RD) W revealed that RD W	F0812		

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F0812 SS = F	Continued from page 15 conducted monthly kitchen audits but did not document the walk-in refrigerator temperature during those audits. DM T stated that she reviewed the temperature logs monthly and believed the temperatures on those logs indicated the internal walk-in refrigerator temperatures were 41 degrees F or lower because none of the documented external thermometer temperatures were 45 degrees F or higher. She did not document any temperatures she observed in the walk-in refrigerator from May 2026 through September 2026. They expected the walk-in refrigerator temperatures to be 41 degrees F or below and confirmed that the documented temperatures were not in that range. 12. Interview and sanitizer bucket log documentation review on 9/10/26 at 10:07 a.m. with cook V and DM T in the main kitchen revealed that cook V documented each time she emptied and refilled the sanitizer solution in the red bucket. She did not document the sanitizer solution concentration but indicated it came from the same system she used to fill the three-compartment sink. She did not test the sanitizer solution concentration throughout the day, but she emptied and refilled the solution at least twice a day. Cook V confirmed that the sanitizer solution in the red bucket was last changed at 5:20 a.m. DM T expected the sanitizer solution in the red bucket to be changed and the sanitizer solution concentration to be tested and documented at least once with each meal prepared, every four hours, or more frequently if the water was dirty. DM T stated that she would not know the sanitizer solution concentration if it was not tested or documented. DM T confirmed the Sanitizer Bucket Log documentation was incomplete but thought that staff changed the sanitizer solution in the red bucket frequently. 13. Review of the Provider's May 2026 through September 2026 Sanitizer Bucket Log revealed "Instructions: Employees will record the reading each time buckes [buckets] are filled. No more then [than] 4 [four] hours between fill[s]." In May 2026, the staff documented filling the sanitizer bucket once on 13 days, twice on 13 days, and three times on 3 days. There was no documentation of the sanitizer solution concentration levels. In June 2026, the staff documented filling the	F0812		

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F0812 SS = F	Continued from page 16 sanitizer bucket once on 15 days, twice on 5 days, and three times on 3 days. There was no documentation of the sanitizer solution concentration levels. In July 2026, the staff documented filling the sanitizer bucket once on 14 days, twice on 11 days, and three times on 5 days. There was no documentation of the sanitizer solution concentration levels. In August 2026, the staff documented filling the sanitizer bucket once on 5 days, twice on 17 days, and eight times on 3 days. There was no documentation of the sanitizer solution concentration levels. In September 2026, the staff documented filling the sanitizer bucket once on 2 days, twice on 4 days, and three times on 1 day. There was no documentation of the sanitizer solution concentration levels. 14. Review of the provider's 8/1/25 Food Temperature policy revealed that "All cold foods need to be maintained and served at a temperature of 41 degrees [F] or below." 15. Review of the provider's 2/18/25 Food Storage policy revealed that "All refrigerator units are kept…in good working condition." "PHF (Potentially Hazardous Food)/TCS (Time/Temperature Control for Safety) food [any food that requires time and temperature control to limit the growth of harmful bacteria or the formation of toxins] must be maintained at or below 41 degrees [F]. Daily temperature logs are completed for all refrigerators." 16. Review of the provider's updated January 2024 Kitchen Sanitization policy revealed "Between uses, cloths and towels used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Sanitizer solution will be changed once per shift or if [the] solution becomes cloudy or visibly dirty."	F0812		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F0600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	**1001 S EGAN AVE , MADISON, South Dakota, 57042**

(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
=0600 SS = E	Continued from page 17 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 (SD) Department of Health (DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to protect the resident's rights to be free from physical and verbal abuse by one of one sampled resident (19), who used his wheelchair to hit the wheelchair of one of one sampled resident (5). Findings include: 1. Review of the provider's 8/19/26 SD DOH FRI revealed that on 8/19/26 at 6:35 p.m., resident 19 was seated in his power wheelchair between the two desks at the nurses' station. The staff present at the time of the incident were contracted travel registered nurse (RN) C, contracted travel licensed practical nurse (LPN) G, and certified nursing assistant (CNA) D. Resident 19 told staff he was going outside one more time for the evening. Resident 5 was seated in his wheelchair to the left of resident 19, near the front of the nurses' desk with his head down and eyes closed. The pathway for resident 19 to reverse his power wheelchair was clear, allowing him to leave the nurses' station. Contracted travel RN C walked around the desk and stood behind resident 5's wheelchair to ensure there were no concerns. Resident 19 reversed out of the area between the two nurses' desks, then said to contracted travel RN C, who was still standing by resident 5, "watch this." Resident 19 then drove his power wheelchair into the right side of resident 5's wheelchair. Resident 19 then verbally insulted resident 5 using profanity. Contracted travel RN C told resident 19 he should not do things like that to other people, and resident 19 said he did not care. Resident 19 was aware that resident 5 had advanced dementia.	F0600	1. Resident #5 was immediately assessed following the 8/19/26 incident for physical injury, pain, psychosocial distress, and changes in condition. Notifications were made to the physician and responsible party. No injuries were identified. The incident was investigated and documented. Resident #19 was immediately removed from contact with Resident #5 and other potentially vulnerable residents while the investigation was conducted. Resident #19 was assessed for behavioral, psychosocial, environmental, and unmet needs contributing to the incident. His care plan was reviewed and revised to address verbally aggressive behaviors, resident-to-resident interactions, use of his power wheelchair, supervision needs, and interventions to reduce the risk of future resident-to-resident altercations. The facility re-educated leadership and staff regarding abuse definitions, resident-to-resident abuse, reporting requirements, and mandatory law enforcement notification when applicable. 2. The Administrator, Director of Nursing, and Social Services Designee completed a comprehensive review of all residents with: • Behavioral symptoms. • Verbal or physical aggression. • Documented altercations with other residents. • Resident-to-resident incidents within the previous six months. • Cognitive impairments that increase vulnerability to abuse. • Behavioral interventions requiring supervision or monitoring. The review included care plans, progress notes, behavior monitoring, incident reports, and interventions implemented to protect residents from abuse. Any resident identified as being at risk for aggressive behaviors or victimization received an immediate care plan review and intervention update.	October 6, 2026

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=0600 SS = E	Continued from page 18 When the staff informed resident 19 that they would report the incident to the SD DOH, he shrugged and said they would not put a guy in a chair in jail. Minimum Data Set (MDS)/RN E called Director of nursing (DON) B. DON B then called administrator A to update her on the incident. Administrator A then advised the staff that resident 19 would need one-to-one staff monitoring when he was out of his room until the incident's investigation was completed. 2. Review of resident 19's electronic medical record (EMR) revealed he admitted to the facility on 8/19/25. His 7/28/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His diagnoses included depression and unspecified mood affective disorder (a clinically recognized mood disturbance that significantly impacts daily functioning or causes distress), and spondylosis of the lumbar region (an age-related degenerative changes in the spine, often related to spinal osteoarthritis). His 8/20/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated that on 8/20/25 that he was responsible for making his own medical decisions. On 9/4/25, the staff documented that he used a power wheelchair with multiple supports and navigated it safely and independently. On 5/6/26, the staff initiated a focus area addressing his degrading name-calling toward other residents. On 7/10/26, they initiated a focus area related to his potential verbal aggression and refusal to follow facility policies. On 8/19/26, documentation indicated that resident 19 ran into resident 5's wheelchair while verbally insulting him. On 8/29/26, the staff were to continue monitoring resident 19's behavior even though resident 5 had passed away. His 7/14/26 progress note indicated that on 7/13/26, resident 19 drove out of his room in his power wheelchair towards resident 5, who was with CNA H and CNA AA. CNA H stepped in between resident 19 and resident 5. Resident 19 then left down the hallway. On 8/19/26, the facility notified resident 19's physician of the incident. His 8/20/26 progress note indicated the ombudsman (an advocate of residents' overall quality of care and rights) was updated about his actions toward resident 5, and that he refused one-on-one monitoring, telling the staff they would not be able to find him outside. DON B instructed the staff that he did not need to be monitored	F0600	3. The facility implemented the following systemic changes: • Re-educated all employees, including licensed nurses, nursing assistants, department managers, activity staff, housekeeping staff, dietary staff, agency personnel, and contracted staff regarding: o F600 Abuse Prevention. o Resident-to-resident abuse. o Definitions of abuse, neglect, and exploitation. o Mandatory reporting requirements. o Recognition of escalating resident behaviors. o Resident protection and supervision requirements. o Immediate intervention expectations. o Reporting incidents through facility reporting systems and to external agencies when required. • Revised the resident-to-resident incident investigation process to ensure: o Thorough investigation of all incidents. o Review of prior related incidents and behavior patterns. o Timely physician, family, state agency, Adult Protective Services, and law enforcement notification when indicated. o Immediate implementation of interim protective measures. • Implemented a high-risk behavior review process through the interdisciplinary team to identify residents demonstrating repeated aggressive, threatening, or intimidating behaviors toward other residents. • Implemented a communication process to ensure all departments, including contracted and agency staff, are informed of residents requiring behavior monitoring, supervision, or protective interventions. • Revised care planning procedures to ensure behavioral incidents result in timely care plan review, intervention implementation, and ongoing monitoring. • Established behavioral management reviews for residents exhibiting repeated aggressive behaviors toward others, including evaluation of psychiatric, psychosocial, environmental, pain-related, and unmet need contributing factors.	

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=0600 3S = E	Continued from page 19 outdoors. An 8/21/26 progress note stated he had no interactions with resident 5 after 8/19/26 and that he was allowed to move about the facility while the staff monitored both residents. 3. Review of resident 5's EMR revealed he admitted to the facility on 1/8/26. His 7/7/26 BIMS assessment score was 2, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) with severe agitation, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) disorder, transient alteration of awareness (a short-lasting episode in which a person's level of alertness, clarity of thinking, or ability to respond appropriately was temporarily impaired), glaucoma, and hearing loss. His 1/28/26 care plan indicated that he used a self-propelled manual wheelchair with anti-tip bars and an anti-rollback device, and the staff assisted him with his mobility as needed due to his cognitive decline. On 4/23/26, the staff added interventions after he demonstrated increased evening and nighttime restlessness, agitation, and confusion. The staff were directed to maintain a consistent daily routine, approach him calmly, provide a quiet, low-stimulation environment, offer reassurance and reorientation, use distraction and soothing activities, promote comfort measures, observe and report behavior changes and triggers and encourage social interaction. His 6/22/26 progress note indicated that he was attempting to hit the staff when resident 19 drove by in his power wheelchair, and the two residents hit each other. RN P stepped in between the residents, and the hitting stopped. Resident 5 remained agitated and wandered the facility but did not hit anyone else. His 8/19/26 progress notes indicated that his wheelchair was hit by resident 19, but he did not have any redness, bruising, or skin issues identified from that incident. His family member was notified of the incident and did not want local law enforcement called. On 8/20/26, his physician was notified of the 8/19/26 incident and suggested the facility report the incident to adult protective services. 4. Interview on 9/8/26 at 1:41 p.m. with resident 19	F0600	4. The Administrator, Director of Nursing, Social Services Designee, or designee will conduct the following audits: Resident-to-Resident Incident Audits • Review of all resident-to-resident altercations, allegations of abuse, and behavioral incidents weekly for four weeks. • Review monthly for two additional months. Care Plan Audits • Weekly audit of five residents identified with aggressive or high-risk behaviors for four weeks. • Monthly audit of five residents for two additional months. • Verification that interventions, monitoring requirements, and resident protections are appropriately implemented and documented. Reporting and Investigation Audits • Weekly review of all incident reports for four weeks. • Monthly review for two additional months. • Verification of compliance with abuse reporting requirements, notifications, investigations, and follow-up actions. The Social Services Designee/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0600 SS = E	Continued from page 20 regarding the incident on 8/19/26 revealed that he stated he had "tapped" resident 5's wheelchair and then DON B told him she was going to file a report with "the state." He said he didn't intend to hurt resident 5, but "if I wanted to hurt him, I would have." 5. Interview on 9/8/26 at 2:33 p.m. with CNA D regarding the incident on 8/19/26 revealed she contacted minimum data set (MDS) RN E to notify her of the situation since she was part of the leadership team and was still in the building. CNA D said that the staff kept resident 19 and resident 5 apart after that incident. 6. Interview on 9/8/26 at 2:40 p.m. with MDS RN E regarding the 8/19/26 incident revealed that once she was notified by CNA D, she called DON B to notify her of the incident. 7. Interview on 9/9/26 at 2:15 p.m. with contracted travel RN C regarding the 8/19/26 incident revealed she completed a skin assessment on resident 5 at the time of the incident, but she did not document it. She said he did not have any injuries, and his personality and mood did not change. 8. Interview on 9/9/26 at 2:23 p.m. with contracted travel LPN G regarding the 8/19/26 incident revealed that she was present at the nurses station on 8/19/26 when resident 19 used his power wheelchair to hit resident 5's wheelchair. She told resident 19, that hitting him with the wheelchair and calling him names was not appropriate. She said that resident 19 "bullied resident 5 all the time." She said he would call him names and curse at him. After the incident, the staff monitored resident 19 when he came out of his room for a couple of days, and he yelled at the staff for monitoring him. The staff kept resident 19 and 5 apart from each other. 9. Interview on 9/9/26 at 2:40 p.m. with DON B regarding the 8/19/26 incident revealed she assessed resident 5 for injuries three times that evening and did not find any. She reviewed the camera video footage and spoke to resident 19 about the incident. Resident 19 told her that hitting resident 5 with his power wheelchair was "just a joke," and was unapologetic about the incident. She then called resident 5's family members to update them on the incident and gave them the option to contact law enforcement, which they declined. The leadership team, which included administrator A, DON B, SSD I, activities coordinator S, and restorative RN F, and MDS RN E, then met on 8/20/26 to update everyone on the incident from	F0600		

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F0600 SS = E	Continued from page 21 8/19/26. The leadership team continued to have the staff monitor him one-on-one while he was out of his room for a couple of days. There was no formal documentation of that, just the staff being aware of where he was in the facility. When he went outside, he was able to go alone. She was aware of the 7/13/26 incident between residents 5 and 19. She watched the camera video footage, but nothing further was done for that incident because the two residents did not make contact. 10. Interview on 9/9/26 at 4:09 p.m. with restorative RN F revealed she expected interventions to be added to the care plan after the July incident with resident 5 and resident 19. She said each care plan should include closer monitoring for each resident. She was not aware of the June incident. 11. Interview on 9/9/26 at 4:15 p.m. with CNA H regarding the 7/13/26 incident with residents 5 and 19 revealed that she and CNA AA were in the hallway by the CNA charting station when resident 5 started grabbing and getting aggressive with them and not wanting to let go of their hands. CNA H then saw resident 19 coming out of his room in his power wheelchair saying, "don't hit women." CNA H said she could tell that resident 19 was going to hit resident 5's wheelchair with his power wheelchair because of how fast he was driving it. CNA H then stood between the two residents, and resident 19 stopped his power wheelchair before hitting her with it. 12. Interview and review of the 8/19/26 video footage on 9/10/26 at 9:36 a.m. with environmental services director (ESD) BB confirmed the information submitted in the provider's 8/19/26 SD DOH FRI. Resident 5's wheelchair was hit hard enough that his upper body shook while he was seated in the wheelchair. 13. Interview on 9/10/26 at 10:30 a.m. with DON B regarding the 8/19/26 incident revealed that DON B determined to leave the contacting of the adult protective services (APS) to the regional long term care ombudsman GG. She and administrator A reviewed a flow sheet to determine whether the incident was a crime, and they determined that it was not. DON B agreed that it was a willful act with the potential to cause harm to a resident who had a cognitive impairment, and from that perspective she understood that law enforcement should have been notified.	F0600		

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F0600 SS = E	Continued from page 22 14. Review of the 7/13/26 staffing daily care sheets (a document that identifies any changes or concerns for a resident each day) revealed that resident 19 was aggressive toward resident 5, would run his power wheelchair into resident 5's wheelchair, and verbally threatened him. 15. Interview on 9/10/26 at 12:13 p.m. with administrator A revealed that she and DON B should have called the police department at the time of the incident on 8/19/20. She said there was no investigation into the 7/13/26 incident that occurred between resident 5 and resident 19. She said resident 19 had issues with everyone at the facility. She, DON B, and social service designee (SSD) I had worked with regional long term care ombudsman GG to discuss the recommendations. The recommendations for resident 19 were to review any unmet needs, review if he had any pain changes, have conversations with him from a trusted person regarding negative attention seeking, have a behavioral contract in place, and review his trauma assessment more deeply. She said everyone in the facility kept an eye out for resident 19 when he was out of his room to ensure everyone's safety. 16. Interview on 9/10/26 at 2:00 p.m. with SSD I revealed she contacted social worker (SW) DD regarding resident 19's incident on 8/19/20. SW DD advised the staff to watch resident 19 and monitor him around resident 5. SSD I and SW DD decided it was "tricky" for the staff to talk to resident 19 without a negative reaction. SSD I was concerned his negative reactions could be taken out on anyone else in the facility. As of 9/10/26, SSD I did not have any conversations with resident 19 about the 8/19/26 incident. She reported that resident 5 did not have any personality changes after the incident. She had completed education with resident 19 "at least five times" on dementia. She said that he had the mentality that residents with dementia were behaving that way intentionally. She said the staff had to watch him when he was out of his room to ensure the other residents were safe. She stated she was trying to "take my time" to approach resident 19 about the 8/19/26 incident because she was "worried and afraid" that he would retaliate against someone else. 17. Interview on 9/10/26 at 2:32 p.m. with CNA L revealed that she knew who resident 19 was but did not know of any behaviors he had or what to watch for when he was out of his room. 18. Interview on 9/10/26 at 2:37 p.m. with contracted	F0600		

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F0600 SS = E	Continued from page 23 travel CNA O revealed she had assisted resident 19 during two scheduled shifts. She said he did not have any behaviors that she was aware of or should have watched for. 19. Interview on 9/10/26 at 2:50 p.m. with RN P revealed that she was present on 6/22/26 when resident 5 and resident 19 hit each other. She notified DON B about the incident. She said they did not monitor resident 19 for any behaviors after resident 5 passed away. 20. Interview on 9/10/26 at 3:00 p.m. with DON B revealed she was not made aware of the incident on 6/22/26. 21. Interview on 9/10/26 at 3:05 p.m. with contracted travel CNA Q revealed he did not know if the staff was supposed to be monitoring resident 19 when he was out of his room. 22. Interview on 9/10/26 at 3:08 p.m. with activities assistant R revealed that she was not aware of any special behaviors they were to monitor resident 19 for. 23. Interview on 9/10/26 at 3:11 p.m. with activities coordinator S revealed that the staff was supposed to keep an eye on resident 19 for where he was, who he was around, and what he was saying. She expected her activities staff to be aware of this for resident 19. 24. Interview and review of the 6/22/26 video footage of resident 19 and 5's incident on 9/10/26 at 3:46 p.m. with DON B, SSD I, and infection preventionist (IP)/RN CC revealed that resident 5 was in the common living room area by the nurse's station waiting for the dining room doors to open for the evening meal. He became agitated, and RN P came over to assist him. He appeared agitated, lunged toward RN P, and RN P moved out of his reach. Resident 19 approached resident 5 in his power wheelchair with his fist up in the air. Resident 5 hit resident 19 on the right arm with a fist. Resident 19 then leaned and punched with a closed fist toward resident 5. The camera angle did not allow verification of whether resident 19 made contact with resident 5 during the altercation. 25. Interview on 9/10/26 at 4:00 p.m. with DON B revealed that she was not notified of the 6/22/26 incident when it occurred. Additional agencies were not notified because they were not aware of the incident until 9/10/26. DON B expected the staff to know how and when to report incidents of	F0600		

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F0600 SS = E	Continued from page 24 suspected abuse and neglect. She acknowledged there were three occurrences over three months, which involved the same two residents, and was a pattern that needed to be addressed to protect the residents at the facility. 26. Interview on 9/10/26 at 4:16 p.m. with RN P revealed that she confirmed that there was physical contact between resident 5 and resident 19 during the 6/22/26 incident in the common living room. She told resident 19 at that time that he could not hit other residents. 27. Interview and review of the 7/13/26 video footage of resident 19 and 5's incident on 7/13/26 at 4:49 p.m. with ESD BB revealed that around 6:00 p.m., resident 5 was grabbing at CNA AA. CNA H then saw resident 19 come out of his room, pointing, and appeared to be talking. CNA H then got up from where she was seated and stepped between resident 19 and resident 5's wheelchair. Resident 19 then left and went down the hallway. No contact was made at that time. 28. Review of the provider's undated Freedom from abuse, neglect and exploitation policy revealed "the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Bethel Lutheran Home does not tolerate abuse, neglect, or exploitation of any kind. Any staff member that has reason to suspect such activity is going on or has witnessed such activity, must immediately report [the] same to the Administrator or his/her designee when [the] Administrator is absent. Prevention: If Bethel Community is unable to meet the needs of a resident, the resident will receive notice and be transferred to an appropriate facility as soon as arrangements can be made. This will include resident/family discussion and physician orders. Resident to resident: the person reporting resident to resident abuse will notify the charge nurse. The charge nurse or social worker will conduct an initial assessment of any resident involved in the incident and document the finding on the Initial Report form [in] the Launch Pad for the Department of Health. The initial staff member who reported the incident and/or witness must provide written statements. The Administrator will be notified of all incidents being reported on the Launch Pad. The family or responsible party for the resident will be contacted by the Administrator, Director of Nursing, or the Social Worker regarding the reported incident. Abuse is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation	F0600		

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=0600 SS = E	Continued from page 25 by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. Neglect means the failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful, as used in the definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."	F0600		
=0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F0880	1. Because reusable resident lift equipment is utilized among multiple residents throughout the facility, all residents who required mechanical lift assistance had the potential to be affected by the deficient practice. Upon identification of the deficient practice, all sit-to-stand lifts and resident lift equipment were immediately removed from service, inspected, and thoroughly cleaned and disinfected according to manufacturer recommendations and facility infection prevention protocols. The debris observed on lift equipment was removed, and all lift equipment was disinfected before being returned to service. The facility discontinued use of inconsistent disinfection practices and standardized the approved disinfection process for lift equipment. Appropriate disinfecting products were identified and standardized, including clear instructions regarding required contact times. All nursing assistants, agency staff, contract staff, licensed nurses, and other staff utilizing resident lift equipment received immediate education regarding cleaning and disinfecting requirements between resident uses and manufacturer recommendations.	October 6, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

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F0880 SS = E	Continued from page 26 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure the staff sanitized reusable lift equipment after each resident's use by two of two observed contract travel certified nursing assistants (CNA) (Q, and N) and one of one observed CNA (JJ). Findings include: 1. Observation on 9/8/26 at 8:37 a.m. in the North resident hall revealed a sit-to-stand lift (a mechanical lift used to assist from a seated position to a standing position) with a significant amount of	F0880	2. The Infection Preventionist (IP), and department managers completed a facility-wide review of reusable resident care equipment, including: • Sit-to-stand lifts. • Mechanical lifts. • Wheelchairs used for multiple residents. • Shower chairs. • Transfer devices. The review verified that equipment cleaning processes were being followed, appropriate disinfectants were available, and staff understood cleaning and disinfection requirements Any concerns identified during the review were immediately corrected. 3. The facility implemented the following systemic changes: • Revised and standardized procedures for cleaning and disinfecting resident lift equipment between each resident use. • Established a single approved disinfectant product for use on resident lift equipment and provided clear instructions regarding required contact times and proper application. • Implemented a lift cleaning checklist and accountability process for routine cleaning and weekly deep cleaning of lift equipment. • Added verification of manufacturer cleaning recommendations to the infection prevention program. • Implemented orientation requirements to ensure all newly hired, agency, and contract staff receive training regarding infection prevention and equipment disinfection processes prior to providing resident care. • Re-educated all nursing staff, agency staff, and contract staff regarding: o F880 Infection Prevention and Control requirements. o Cleaning and disinfecting shared resident-care equipment. o Manufacturer instructions for use. o Contact times for disinfectants. o Prevention of cross-contamination and transmission of infectious organisms. • Reinforced supervisory responsibility to ensure lift equipment is cleaned immediately after resident use and maintained free of debris and contamination	

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=0880 3S = E	Continued from page 27 debris including dirt, food and crumbs on the lift's foot pedals. 2. Observation on 9/9/26 at 9:25 a.m. in the West resident hall revealed an sit-to-stand lift with a significant amount of debris on it. 3. Observation and interview on 9/9/26 at 12:35 p.m. with contracted travel CNA Q and certified medication aide (CMA) II revealed he was spraying a sit-to-stand lift with Lysol disinfectant spray. When asked how long the spray needed to sit (the contact time) before using the lift on a different resident, he stated "I think seven or eight minutes." CMA II overheard the conversation and stated that the contact time was 10 minutes. 4. Observation and interview on 9/9/26 at 12:40 p.m. with CNA JJ revealed that CNA JJ had just finished using a lift in resident 39's room and did not clean the lift after use. When asked if she was supposed to clean the lift after use, she replied that she did not clean the lift, but would clean it before using it on another resident. 5. Observation and interview on 9/9/26 at 12:50 p.m. with contracted travel CNA N revealed that CNA N had just used the sit-to-stand lift and did not clean it after using it. When asked if she had cleaned the lift, she answered that she did not. When asked what the process was for cleaning resident lift equipment, she stated "This is my first day. Honestly, I don't know. They have a spray." When asked if she was trained on the process of cleaning lift equipment before starting her employment, she said that she was not trained. 6. Observation and interview on 9/10/26 at 8:10 a.m. with contracted travel CNA Q revealed that contracted travel CNA Q had used the sit-to-stand lift and was cleaning it with a disinfectant wipe. When asked why he was using a wipe instead of the spray he had previously used, he responded "I have no idea." 7. Interview on 9/10/26 at 9:57 a.m. with infection preventionist (IP)/registered nurse (RN) CC revealed that the facility started using disinfecting wipes instead of the spray to disinfect the equipment that morning because more than one type of spray was being used, and some of the sprays required the equipment to sit for 10-15 minutes. The disinfectant wipes have a contact time of one minute. That was the reason for the change. She expected the staff to clean the lift equipment after each resident use. She reported that lifts were to be completely wiped down	F0880	4. The Infection Preventionist or designee will conduct the following monitoring: Equipment Cleaning Audits • Audit ten observations of shared resident-care equipment use weekly for four weeks. • Audit ten observations monthly for two additional months. Audits will verify: • Equipment is cleaned and disinfected after each resident use. • Appropriate disinfectant products are utilized. • Required contact times are followed. • Equipment remains free of debris and contamination. • Staff demonstrate proper cleaning procedures. The Infection Preventionist or designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0880 SS = E	Continued from page 28 weekly by the CNAs and documented on a checklist when completed. IP/RN CC reported that the dirt and debris buildup on the lifts was an infection control concern. The lift cleaning checklist was requested and was not provided by the end of the survey. 8. Interview on 9/10/26 at 2:53 p.m. with CNA KK revealed that the lift should be cleaned after each resident use. Her process for cleaning the lift was to spray the lift with the disinfectant spray and let it sit for at least one minute. She agreed that the sit-to-stand lift in the north hall was dirty and should be cleaned before being used on the next resident. 9. Interview on 9/10/26 at 4:40 p.m. with director of nursing (DON) B revealed that she expected the staff to clean the resident lift equipment after each use. She reported that the buildup of dirt and debris was an infection control concern and was not acceptable. 10. Review of the provider's 2001 Infection Prevention and Control Policies and Procedures revealed "2. The objectives of the infection prevention and control policies and procedures are to: a. monitor, prevent, detect, investigate, and control infections in the facility. b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; and c. provide evidence-based guidelines for infection prevention and control based on current best practices. 5. All personnel are trained on infection prevention and control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control." 11. Review of the provider's 2001 Cleaning and Disinfection of Resident-Care Items and Equipment policy revealed "Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions." 12. Review of the February 2026 EZ Way Equipment Cleaning Guide revealed "To keep your EZ Way equipment clean and in good condition, we recommend you use a standard germicidal spray, Sani-Wipe, or similar product and you follow these guidelines: DO NOT SPRAY PRODUCT DIRECTLY ON THE MACHINE."	F0880		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F0554		

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=0554 3S = D	Continued from page 29 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure residents were assessed and had a physician's order to safely administer nebulizer (a device that converts liquid medication into an inhalable mist) treatments for one of two sampled residents (35), who self-administered her nebulizer treatment without a completed medication self-assessment or a physician's order for that medication. Findings include: 1. Observation and interview on 9/8/26 at 9:55 a.m. with resident 35 in her room revealed that she used a nebulizer machine. The mouthpiece was attached to the nebulizer machine and was on her bedside table. She stated that the staff brought in the nebulizer medication at least twice daily, and she completed the nebulizer treatment and would shut the machine off. 2. Review of resident 35's electronic medical record (EMR) revealed that she admitted to the facility on 4/29/26. Her diagnoses included chronic obstructive pulmonary disease (COPD a group of lung diseases that block airflow and make it difficult to breathe) and shortness of breath. Her 8/4/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 4/29/26 physician's order for Albuterol Sulfate Inhalation Nebulization Solution 2.5 mg (milligrams)/3mL (milliliters) 0.083% (percent) (Albuterol Sulfate) to be administered orally via a nebulizer every four hours as needed for wheezing related to chronic obstructive pulmonary disease. She had a 5/11/26 physician's order for Arformoterol Tartrate Inhalation Nebulization Solution 15 mcg (micrograms)/2mL to be administered orally via a nebulizer once daily for shortness of breath at 7:00 a.m. She had a 5/11/26 physician's order for "Arformoterol Tartrate Inhalation Nebulization Solution 15 mcg/2mL to be administered orally via a nebulizer once daily for shortness of breath at 4:30	F0554	1. Resident #35 was assessed by the Director of Nursing (DON) and licensed nursing staff regarding her ability to safely self-administer nebulizer treatments and medications. A comprehensive self-medication assessment was completed in accordance with facility policy. The attending physician was notified of the findings and a physician order was obtained addressing self-administration of nebulizer treatments. Until the assessment and physician order process were completed, licensed staff remained responsible for administration and monitoring of nebulizer medications in accordance with physician orders. Resident #35's care plan was reviewed and updated to reflect her assessed ability to self-administer medications, supervision requirements, and monitoring needs. Nursing staff were educated regarding physician order requirements and the facility's self-administration policy. 2. The DON or designee completed a 100% audit of all residents who: • Self-administer medications. • Self-administer inhalers, nebulizer treatments, eye drops, topical medications, or other treatments. • Store medications at the bedside. • Have physician orders permitting self-administration. The audit included review of: • Self-administration assessments. • Physician orders authorizing self-administration. • Resident education documentation. • Care plans. • Ongoing competency evaluations. Any resident identified without an appropriate assessment, physician order, care plan, or documentation received immediate follow-up and correction.	October 6, 2026

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F0554 SS = D	Continued from page 30 p.m. She had a 5/11/26 physician's order for Budesonide Inhalation Suspension 0.5 mg/2mL to be administered orally via a nebulizer once daily for COPD at 7:00 a.m., with instructions to "RINSE MOUTH after each use." There was no documentation that a medication self-assessment was completed for resident 35, and no physician's order indicated that resident 35 could self-administer those medications. 3. Observation and interview on 9/9/26 at 4:18 p.m. with contracted travel licensed practical nurse (LPN) HH revealed that she entered resident 35's room to administer resident 35's nebulizer treatment. Resident 35 handed LPN HH the nebulizer mouthpiece attached to the nebulizer machine. LPN HH put the nebulizer medication in the well of the mouthpiece and reassembled it, handed the mouthpiece to resident 35, turned on the machine, stated that she would return in fifteen minutes, and left the room. 4. Continued observation on 9/9/26 at 4:20 p.m. of LPN HH and resident 35 from the hallway outside of resident 35's room revealed that LPN HH continued to assist other residents in that hallway and in their rooms. At 4:29 p.m., resident 35 turned off her nebulizer machine. At 4:36 p.m., LPN HH returned to resident 35's room as resident 35 and her family member exited the room. LPN HH asked resident 35 if she had finished her nebulizer treatment. Resident 35 indicated that she had. 5. Interview and review of resident 35's EMR on 9/10/26 at 9:15 a.m. with certified medication aide (CMA) II revealed that she administered resident 35's nebulizer treatment that morning. She did not stay with resident 35 when she completed her nebulizer treatments because she was told resident 35 was able to self-administer those treatments. CMA II reviewed resident 35's EMR and was unable to find documentation that resident 35 was able to self-administer her medications. 6. Interview on 9/10/26 at 1:51 p.m. with DON B revealed that she expected that a medication self-administration assessment would have been completed for resident 35 when she admitted to the facility and that a physician's order would have	F0554	3 The facility implemented the following systemic changes: • Re-educated licensed nurses, medication aides, agency staff, and contract staff regarding: o F554 Resident Rights. o Resident rights related to self-administration of medications. o Facility self-administration and bedside medication storage policies. o Requirements for physician orders authorizing self-administration. o Completion and documentation of self-administration assessments. o Ongoing competency evaluations and reassessments. • Implemented an admission checklist review process requiring verification that: o Self-administration assessments are completed when applicable. o Physician orders are obtained before self-administration begins. o Care plans are updated appropriately. o Resident education is documented. • Implemented quarterly reviews of all residents approved to self-administer medications to ensure continued competency and compliance with physician orders and facility policy. • Established supervisory review of all newly approved self-administration requests by the DON or designee prior to implementation 4. The DON or designee will conduct audits as follows: Self-Administration Audits • Weekly audit of five residents who self-administer medications for four weeks. • Monthly audit of five residents for two additional months. The audits will verify: • Completion of self-administration assessments. • Presence of physician orders authorizing self-administration. • Documentation of resident education. • Appropriate care plan interventions. • Ongoing competency evaluations. • Compliance with facility policy.	

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F0554 SS = D	Continued from page 31 been obtained for resident 35 to self-administer her nebulizer treatments because she believed resident 35 could self-administer her nebulizer treatments. She thought the assessment was overlooked because the nurse responsible for completing resident 25's admission assessments was new to that role at the facility. 7. Review of the provider's May 2025 Self Administration/Bedside Storage of Medication Policy revealed the "Residents have the right to self-administer (SA) their own medications with nursing supervision, but only after evaluation by the Registered Nurse, and determines the practice to be safe and the resident to be an appropriate candidate." "Prior to SA, The Registered Nurse will document their evaluation findings...a physician's order allowing this practice will be placed in the resident's medical chart...the resident will be educated on responsibilities of SA and documentation of this teaching will be recorded...A self-administration assessment is to be completed every three months to ensure the resident continues to be competent to self-administer."	F0554	4. Continued Admission Audits • Weekly review of all new admissions for four weeks. • Monthly review for two additional months. The audits will verify appropriate completion of assessments, physician orders, and care planning related to self-administration of medications. The DON/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance	F0609		

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F0609 SS = D	Continued from page 32 with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota (SD) Department of Health (DOH) facility-reported incidents (FRI), record review, interview, and policy review, the provider failed to report alleged abuse involving two of three resident-to-resident incidents between two of two residents (5 and 19) to law enforcement or adult protective services. Findings include: 1. Review of the provider's 8/19/26 SD DOH FRI revealed that on 8/19/26 at 6:35 p.m., resident 19 was seated in his power wheelchair between the two desks at the nurses' station. The staff present at the time of the incident were contracted travel registered nurse (RN) C, contracted travel licensed practical nurse (LPN) G, and certified nursing assistant (CNA) D. Resident 19 told staff he was going outside one more time for the evening. Resident 5 was seated in his wheelchair to the left of resident 19, near the front of the nurses' desk with his head down and eyes closed. The pathway for resident 19 to reverse his power wheelchair was clear, allowing him to leave the nurses' station. Contracted travel RN C walked around the desk and stood behind resident 5's wheelchair to ensure there were no concerns. Resident 19 reversed out of the area between the two nurses' desks, then said to contracted travel RN C, who was still standing by resident 5, "watch this." Resident 19 then drove his power wheelchair into the right side of resident 5's wheelchair. Resident 19 then verbally insulted resident 5 using profanity. Contracted travel RN C told resident 19 he should not do things like that to other people, and resident 19 said he did not care. Resident 19 was aware that resident 5 had advanced dementia. When the staff informed resident 19 that they would report the incident to the SD DOH, he shrugged and said they would not put a guy in a chair in jail. Minimum Data Set (MDS)/RN E called Director of nursing (DON) B. DON B then called administrator A to update her on the incident. Administrator A then advised the staff that resident 19 would need one-to-one staff monitoring when he was out of his room until the incident's investigation was completed.	F0609	1. The facility reviewed the resident-to-resident incidents involving Residents #5 and #19, including the events occurring on 6/22/26, 7/13/26, and 8/19/26. The Administrator and Director of Nursing conducted a review of the facility's abuse reporting process and reporting obligations related to resident-to-resident abuse allegations. Appropriate notifications were completed according to state and federal reporting requirements for alleged abuse, including notification to applicable agencies as required. Resident #19's care plan, behavioral interventions, supervision requirements, and monitoring plans were reviewed and revised to address aggressive, threatening, and abusive behaviors toward other residents. Staff were re-educated regarding immediate reporting requirements for suspected abuse and resident-to-resident altercations. The facility reviewed documentation, investigations, and notifications associated with the identified incidents to ensure appropriate protective measures were implemented. 2. The Administrator, Director of Nursing, and Social Services Designee completed a 100% review of all allegations, incidents, accidents, behavioral events, abuse investigations, and resident-to-resident altercations occurring during the previous six months.	October 6, 2026

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F0609 SS = D	Continued from page 33 2. Review of resident 19's electronic medical record (EMR) revealed he admitted to the facility on 8/19/25. His 7/28/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His diagnoses included depression and unspecified mood affective disorder (a clinically recognized mood disturbance that significantly impacts daily functioning or causes distress), and spondylosis of the lumbar region (an age-related degenerative changes in the spine, often related to spinal osteoarthritis). His 8/20/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated that on 8/20/25 that he was responsible for making his own medical decisions. On 9/4/25, the staff documented that he used a power wheelchair with multiple supports and navigated it safely and independently. On 5/6/26, the staff initiated a focus area addressing his degrading name-calling toward other residents. On 7/10/26, they initiated a focus area related to his potential verbal aggression and refusal to follow facility policies. On 8/19/26, documentation indicated that resident 19 ran into resident 5's wheelchair while verbally insulting him. On 8/29/26, the staff were to continue monitoring resident 19's behavior even though resident 5 had passed away. His 7/14/26 progress note indicated that on 7/13/26, resident 19 drove out of his room in his power wheelchair towards resident 5, who was with CNA H and CNA AA. CNA H stepped in between resident 19 and resident 5. Resident 19 then left down the hallway. On 8/19/26, the facility notified resident 19's physician of the incident. His 8/20/26 progress note indicated the ombudsman (an advocate of residents' overall quality of care and rights) was updated about his actions toward resident 5, and that he refused one-on-one monitoring, telling the staff they would not be able to find him outside. DON B instructed the staff that he did not need to be monitored outdoors. An 8/21/26 progress note stated he had no interactions with resident 5 after 8/19/26 and that he was allowed to move about the facility while the staff monitored both residents. 3. Review of resident 5's EMR revealed he admitted to the facility on 1/8/26. His 7/7/26 BIMS assessment score was 2, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory,	F0609	2. continued The review included verification that: • Appropriate internal reporting occurred. • State agency reporting requirements were met. • Law enforcement notifications were completed when required. • Investigations were initiated timely. • Protective interventions were implemented. • Care plans were updated. Any identified concerns were immediately corrected. 3.The facility implemented the following systemic changes: • Re-educated all facility staff, including licensed nurses, nursing assistants, department managers, agency personnel, contract staff, and leadership regarding: o F609 Reporting of Alleged Violations. o Federal and state abuse reporting requirements. o Reporting timelines. o Resident-to-resident abuse allegations. o Mandatory reporting to law enforcement and Adult Protective Services when applicable. o Documentation requirements. o Immediate protective actions for involved residents. • Revised the facility abuse reporting process to include an Abuse Reporting Checklist to ensure: o Timely notification of the Administrator and Director of Nursing. o Determination of reporting requirements. o Documentation of agency notifications. o Documentation of investigation activities. o Monitoring of completion timelines. • Implemented leadership review of all resident-to-resident incidents and allegations of abuse within 24 hours to assure all reporting requirements are met. • Implemented a standardized investigation tool to ensure prior incidents, behavioral patterns, risk factors, and protective interventions are evaluated and documented. • Added abuse reporting requirements and reporting pathways to orientation for all newly hired, agency, and contract staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0609 SS = D	Continued from page 34 thinking, social abilities, and body functions), unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) with severe agitation, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) disorder, transient alteration of awareness (a short-lasting episode in which a person's level of alertness, clarity of thinking, or ability to respond appropriately was temporarily impaired), glaucoma, and hearing loss. His 1/28/26 care plan indicated that he used a self-propelled manual wheelchair with anti-tip bars and an anti-rollback device, and the staff assisted him with his mobility as needed due to his cognitive decline. On 4/23/26, the staff added interventions after he demonstrated increased evening and nighttime restlessness, agitation, and confusion. The staff were directed to maintain a consistent daily routine, approach him calmly, provide a quiet, low-stimulation environment, offer reassurance and reorientation, use distraction and soothing activities, promote comfort measures, observe and report behavior changes and triggers and encourage social interaction. His 6/22/26 progress note indicated that he was attempting to hit the staff when resident 19 drove by in his power wheelchair, and the two residents hit each other. RN P stepped in between the residents, and the hitting stopped. Resident 5 remained agitated and wandered the facility but did not hit anyone else. His 8/19/26 progress notes indicated that his wheelchair was hit by resident 19, but he did not have any redness, bruising, or skin issues identified from that incident. His family member was notified of the incident and did not want local law enforcement called. On 8/20/26, his physician was notified of the 8/19/26 incident and suggested the facility report the incident to adult protective services. 4. Interview on 9/8/26 at 1:41 p.m. with resident 19 regarding the incident on 8/19/26 revealed that he stated he had "tapped" resident 5's wheelchair and then DON B told him she was going to file a report with "the state." He said he didn't intend to hurt resident 5, but "if I wanted to hurt him, I would have." 5. Interview on 9/8/26 at 2:33 p.m. with CNA D regarding the incident on 8/19/26 revealed she contacted minimum data set (MDS) RN E to notify her of the situation since she was part of the	F0609	4. The Administrator or designee will complete: Incident Reporting Audits • Weekly review of all incidents, allegations, accidents, and abuse investigations for four weeks. • Monthly review for two additional months. Audits will verify: • Timely recognition and reporting of alleged violations. • Compliance with state and federal notification requirements. • Notification of law enforcement when required. • Notification of Adult Protective Services when required. • Completion of investigations. • Implementation of resident protection measures. • Appropriate care plan updates. Staff Knowledge Audits • Weekly staff interviews and competency reviews for four weeks. • Monthly reviews for two additional months. Audits will verify staff understanding of abuse reporting expectations and mandatory reporting requirements. The Administrator/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0609 SS = D	Continued from page 35 leadership team and was still in the building. CNA D said that the staff kept resident 19 and resident 5 apart after that incident. 6. Interview on 9/8/26 at 2:40 p.m. with MDS RN E regarding the 8/19/26 incident revealed that once she was notified by CNA D, she called DON B to notify her of the incident. 7. Interview on 9/9/26 at 2:15 p.m. with contracted travel RN C regarding the 8/19/26 incident revealed she completed a skin assessment on resident 5 at the time of the incident, but she did not document it. She said he did not have any injuries, and his personality and mood did not change. 8. Interview on 9/9/26 at 2:23 p.m. with contracted travel LPN G regarding the 8/19/26 incident revealed that she was present at the nurses station on 8/19/26 when resident 19 used his power wheelchair to hit resident 5's wheelchair. She told resident 19, that hitting him with the wheelchair and calling him names was not appropriate. She said that resident 19 "bullied resident 5 all the time," She said he would call him names and curse at him. After the incident, the staff monitored resident 19 when he came out of his room for a couple of days, and he yelled at the staff for monitoring him. The staff kept resident 19 and 5 apart from each other. 9. Interview on 9/9/26 at 2:40 p.m. with DON B regarding the 8/19/26 incident revealed she was called by MDS RN E after the incident happened on 8/19/26. She said she then came into the building to start the investigation and notified Administrator A on the way into the facility. She assessed resident 5 for injuries three times that evening and did not find any. She reviewed the camera video footage and spoke to resident 19 about the incident. Resident 19 told her that hitting resident 5 with his power wheelchair was "just a joke." and was unapologetic about the incident. She then called resident 5's family members to update them on the incident and gave them the option to contact law enforcement, which they declined. The leadership team, which included administrator A, DON B, SSD I, activities coordinator S, and restorative RN F, and MDS RN E, then met on 8/20/26 to update everyone on the incident from 8/19/26. The leadership team continued to have the staff monitor him one-on-one while he was out of his room for a couple of days. There was no formal documentation of that, just the staff being aware of where he was in the facility. When he went outside, he was able to go alone. She was aware of the 7/13/26 incident between	F0609		

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F0609 SS = D	Continued from page 36 residents 5 and 19. She watched the camera video footage, but nothing further was done for that incident because the two residents did not make contact. 10. Interview on 9/9/26 at 4:09 p.m. with restorative RN F revealed she expected interventions to be added to the care plan after the July incident with resident 5 and resident 19. She said each care plan should include closer monitoring for each resident. She was not aware of the June incident. 11. Interview on 9/9/26 at 4:15 p.m. with CNA H regarding the 7/13/26 incident with residents 5 and 19 revealed that she and CNA AA were in the hallway by the CNA charting station when resident 5 started grabbing and getting aggressive with them and not wanting to let go of their hands. CNA H then saw resident 19 coming out of his room in his power wheelchair saying, "don't hit women." CNA H said she could tell that resident 19 was going to hit resident 5's wheelchair with his power wheelchair because of how fast he was driving it. CNA H then stood between the two residents, and resident 19 stopped his power wheelchair before hitting her with it. 12. Interview and review of the 8/19/26 video footage on 9/10/26 at 9:36 a.m. with environmental services director (ESD) BB confirmed the information submitted in the provider's 8/19/26 SD DOH FRI. Resident 5's wheelchair was hit hard enough that his upper body shook while he was seated in the wheelchair. 13. Interview on 9/10/26 at 10:30 a.m. with DON B regarding the 8/19/26 incident revealed that DON B determined to leave the contacting of the adult protective services (APS) to the regional long term care ombudsman GG. She and administrator A reviewed a flow sheet to determine whether the incident was a crime, and they determined that it was not. DON B agreed that it was a willful act with the potential to cause harm to a resident who had a cognitive impairment, and from that perspective she understood that law enforcement should have been notified. 14. Review of the 7/13/26 staffing daily care sheets (a document that identifies any changes or concerns for a resident each day) revealed that resident 19 was aggressive toward resident 5, would run his power wheelchair into resident 5's wheelchair, and verbally threatened him. 15. Interview on 9/10/26 at 12:13 p.m. with	F0609		

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F0609 SS = D	Continued from page 37 administrator A revealed that she and DON B completed a flow sheet to determine if the incident on 8/19/26 was a crime. They did take into account that the family did not want the police notified; however, in hindsight, knowing it was a willful act with the potential to harm another resident, administrator A said she and/or DON B should have called the police department at the time of the 8/19/26 incident. She said there was no investigation into the 7/13/26 incident that occurred between resident 5 and resident 19. She said resident 19 had issues with everyone at the facility. She, DON B, and social service designee (SSD) I had worked with regional long term care ombudsman GG to discuss the recommendations. The recommendations for resident 19 were to review any unmet needs, review if he had any pain changes, have conversations with him from a trusted person regarding negative attention seeking, have a behavioral contract in place, and review his trauma assessment more deeply. She said everyone in the facility kept an eye out for resident 19 when he was out of his room to ensure everyone's safety. 16. Interview on 9/10/26 at 2:00 p.m. with SSD I revealed she was not around for the 8/19/26 incident. She contacted social worker (SW) DD regarding resident 19's incident on 8/19/20. SW DD advised the staff to watch resident 19 and monitor him around resident 5. SSD I and SW DD decided it was "tricky" for the staff to talk to resident 19 without a negative reaction. SSD I was concerned his negative reactions could be taken out on anyone else in the facility. As of 9/10/26, SSD I did not have any conversations with resident 19 about the 8/19/26 incident. She reported that resident 5 did not have any personality changes after the incident. She had completed education with resident 19 "at least five times" on dementia. She said that he had the mentality that residents with dementia were behaving that way intentionally. She said the staff had to watch him when he was out of his room to ensure the other residents were safe. She stated she was trying to "take my time" to approach resident 19 about the 8/19/26 incident because she was "worried and afraid" that he would retaliate against someone else. 17. Interview on 9/10/26 at 2:32 p.m. with CNA L revealed that she knew who resident 19 was but did not know of any behaviors he had or what to watch for when he was out of his room. 18. Interview on 9/10/26 at 2:37 p.m. with contracted travel CNA O revealed she had assisted resident 19	F0609		

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F0609 SS = D	Continued from page 38 during two scheduled shifts. She said he did not have any behaviors that she was aware of or should have watched for. 19. Interview on 9/10/26 at 2:50 p.m. with RN P revealed that she was present on 6/22/26 when resident 5 and resident 19 hit each other. She notified DON B about the incident. She said they did not monitor resident 19 for any behaviors after resident 5 passed away. 20. Interview on 9/10/26 at 3:00 p.m. with DON B revealed she was not made aware of the incident on 6/22/26. 21. Interview on 9/10/26 at 3:05 p.m. with contracted travel CNA Q revealed he did not know if the staff was supposed to be monitoring resident 19 when he was out of his room. 22. Interview on 9/10/26 at 3:08 p.m. with activities assistant R revealed that she was not aware of any special behaviors they were to monitor resident 19 for. 23. Interview on 9/10/26 at 3:11 p.m. with activities coordinator S revealed that the staff was supposed to keep an eye on resident 19 for where he was, who he was around, and what he was saying. She expected her activities staff to be aware of this for resident 19. 24. Interview and review of the 6/22/26 video footage of resident 19 and 5's incident on 9/10/26 at 3:46 p.m. with DON B, SSD I, and infection preventionist (IP)/RN CC revealed that resident 5 was in the common living room area by the nurse's station waiting for the dining room doors to open for the evening meal. He became agitated, and RN P came over to assist him. He appeared agitated, lunged toward RN P, and RN P moved out of his reach. Resident 19 approached resident 5 in his power wheelchair with his fist up in the air. Resident 5 hit resident 19 on the right arm with a fist. Resident 19 then leaned and punched with a closed fist toward resident 5. The camera angle did not allow verification of whether resident 19 made contact with resident 5 during the altercation. 25. Interview on 9/10/26 at 4:00 p.m. with DON B revealed that she was not notified of the 6/22/26 incident when it occurred. Additional agencies were not notified because they were not aware of the incident until 9/10/26. DON B expected the staff to know how and when to report incidents of suspected abuse and neglect. She acknowledged	F0609		

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F0609 SS = D	Continued from page 39 there were three occurrences over three months, which involved the same two residents, and was a pattern that needed to be addressed to protect the residents at the facility. 26. Interview on 9/10/26 at 4:16 p.m. with RN P revealed that she confirmed that there was physical contact between resident 5 and resident 19 during the 6/22/26 incident in the common living room. She told resident 19 at that time that he could not hit other residents. 27. Interview and review of the 7/13/26 video footage of resident 19 and 5's incident on 7/13/26 at 4:49 p.m. with ESD BB revealed that around 6:00 p.m., resident 5 was grabbing at CNA AA. CNA H then saw resident 19 come out of his room, pointing, and appeared to be talking. CNA H then got up from where she was seated and stepped between resident 19 and resident 5's wheelchair. Resident 19 then left and went down the hallway. No contact was made at that time. 28. Review of the provider's undated Freedom from abuse, neglect and exploitation policy revealed " the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Bethel Lutheran Home does not tolerate abuse, neglect, or exploitation of any kind. Any staff member that has reason to suspect such activity was going on or has witnessed such activity, must immediately report same to the Administrator or his/her designee when Administrator is absent. Prevention: If bethel Community is unable to meet the needs of a resident, the resident will receive notice and be transferred to an appropriate facility as soon as arrangements can be made. This will include resident/family discussion and physician orders. Resident to resident the person reporting resident to resident abuse will notify the charge nurse. The charge nurse or social worker will conduct an initial assessment of any resident involved in the incident and document the finding on the Initial Report form the Launch Pad for the Department of Health. The initial staff member who reported the incident and/or witness must provide written statements. The Administrator will be notified of all incidents being reported on the Launch Pad. The family or responsible party for the resident will be contacted by the Administrator, Director of Nursing, or the Social Worker regarding the reported incident. Abuse is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or	F0609		

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F0609 SS = D	Continued from page 40 services that are necessary ot attain or maintain physical, mental and psychosocial wellbeing. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical hard, pain or mental anguish. Neglect means the failure of the facility, its employees or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful as used in the definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm."	F0609		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota (SD) Department of Health (DOH) facility-reported incident (FRI), record review, interview, and policy review, the facility failed to ensure an environment free of accident hazards and did not provide adequate supervision of one of one sampled resident (19) to prevent two resident-to-resident incidents involving the unsafe operation of a power wheelchair. Findings include: 1. Review of the provider's 8/19/26 SD DOH FRI revealed that on 8/19/26 at 6:35 p.m., resident 19 was seated in his power wheelchair between the two desks at the nurses' station. The staff present at the time of the incident were contracted travel registered nurse (RN) C, contracted travel licensed practical nurse (LPN) G, and certified nursing assistant (CNA) D. Resident 19 told staff he was going outside one more time for the evening. Resident 5 was seated in his wheelchair to the left of resident 19, near the front of the nurses' desk with his head down and eyes closed. The pathway for resident 19 to reverse his power wheelchair was clear, allowing him to leave the nurses' station.	F0689		

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=0689 SS = D	Continued from page 41 Contracted travel RN C walked around the desk and stood behind resident 5's wheelchair to ensure there were no concerns. Resident 19 reversed out of the area between the two nurses' desks, then said to contracted travel RN C, who was still standing by resident 5, "watch this." Resident 19 then drove his power wheelchair into the right side of resident 5's wheelchair. Resident 19 then verbally insulted resident 5 using profanity. Contracted travel RN C told resident 19 he should not do things like that to other people, and resident 19 said he did not care. Resident 19 was aware that resident 5 had advanced dementia. When the staff informed resident 19 that they would report the incident to the SD DOH, he shrugged and said they would not put a guy in a chair in jail. Minimum Data Set (MDS)/RN E called Director of nursing (DON) B. DON B then called administrator A to update her on the incident. Administrator A then advised the staff that resident 19 would need one-to-one staff monitoring when he was out of his room until the incident's investigation was completed. Resident 19 made his own decisions and did not have family to contact. Staff contacted a family member for resident 5. 2. Review of resident 19's electronic medical record (EMR) revealed he admitted to the facility on 8/19/25. His 7/28/26 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated his cognition was intact. His diagnoses included depression and unspecified mood affective disorder (a clinically recognized mood disturbance that significantly impacts daily functioning or causes distress), and spondylosis of the lumbar region (an age-related degenerative changes in the spine, often related to spinal osteoarthritis). His 8/20/25 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated that on 8/20/25 that he was responsible for making his own medical decisions. On 9/4/25, the staff documented that he used a power wheelchair with multiple supports and navigated it safely and independently. On 5/6/26, the staff initiated a focus area addressing his degrading name-calling toward other residents. On 7/10/26, they initiated a focus area related to his potential verbal aggression and refusal to follow facility policies. On 8/19/26, documentation indicated that resident 19 ran into resident 5's wheelchair while verbally insulting him. On 8/29/26, the staff were to continue monitoring resident 19's behavior even though resident 5 had passed away.	F0689	1. Resident #19 was assessed by the interdisciplinary team following the identified resident-to-resident incidents involving unsafe operation of his power wheelchair. The assessment included evaluation of behavioral triggers, resident rights, power wheelchair safety, cognition, judgment, psychosocial needs, and potential risk to other residents. A formal interdisciplinary review of Resident #19's continued use of a power wheelchair was completed. Physical Therapy, Nursing, Social Services, and the attending physician participated in evaluating the resident's ability to safely operate the device within the facility environment. The resident's care plan was revised to include interventions addressing supervision, behavioral monitoring, risk for resident-to-resident altercations, environmental awareness, and safe operation of the power wheelchair. Resident #5 was assessed at the time of the incident for injury, changes in condition, psychosocial distress, and need for additional interventions. Staff received immediate instruction regarding supervision and monitoring expectations for residents exhibiting unsafe behaviors. 2. The Director of Nursing, Therapy Department, Social Services, and Administrator completed a facility-wide review of residents who: · Utilize power wheelchairs or motorized mobility devices. · Have documented behavioral concerns. · Have a history of resident-to-resident incidents. · Demonstrate impaired judgment, impulsive behaviors, aggression, or unsafe mobility practices. · Require supervision for mobility or environmental safety. The review included evaluation of: · Power wheelchair assessments. · Nursing assessments. · Care plans. · Incident reports. · Behavior monitoring documentation. · Therapy evaluations. · Supervision interventions. Any resident identified as requiring additional assessment, supervision, care planning, or therapy evaluation received immediate follow-up.	October 6, 2026

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F0689 SS = D	Continued from page 42 His 8/18/25 physical therapy notes indicated that the physical therapy department at another facility completed a power wheelchair evaluation before his admission to the facility. The completed assessment notes indicated that he could select appropriate speeds and negotiate barriers and pedestrians without difficulty. It indicated that he was informed that he should use the power wheelchair with caution in his new facility and that, if accidents occur or staff at his new facility feel he was unsafe around other residents, the facility had the right to deny him use of the device. Within this assessment, it was documented that resident 19 voiced understanding of these conditions and agreed to use the device safely. His 7/28/26 care conference notes indicated that he had a personal power wheelchair with multiple supports and could manage it independently. His 7/14/26 progress note indicated that on 7/13/26, resident 19 drove out of his room in his power wheelchair towards resident 5, who was with CNA H and CNA AA. CNA H stepped in between resident 19 and resident 5. Resident 19 then left down the hallway. On 8/19/26, the facility notified resident 19's physician of the incident. His 8/20/26 progress note indicated the ombudsman (an advocate of residents' overall quality of care and rights) was updated about his actions toward resident 5, and that he refused one-on-one monitoring, telling the staff they would not be able to find him outside. DON B instructed the staff that he did not need to be monitored outdoors. An 8/21/26 progress note stated he had no interactions with resident 5 after 8/19/26 and that he was allowed to move about the facility while the staff monitored both residents. 3. Review of resident 5's EMR revealed he admitted to the facility on 1/8/26. His 7/7/26 BIMS assessment score was 2, which indicated his cognition was severely impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) with severe agitation, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability) disorder, transient alteration of awareness (a short-lasting episode in which a person's level of alertness, clarity of thinking, or ability to respond appropriately was temporarily impaired), glaucoma,	F0689	3. The facility implemented the following systemic changes: • Re-educated all staff, including licensed nurses, nursing assistants, therapy personnel, agency staff, contract staff, and department leaders regarding: o F689 Accident Prevention. o Resident supervision requirements. o Resident-to-resident risk identification. o Reporting and documenting unsafe behaviors. o Implementation of interventions to prevent avoidable accidents. o Monitoring residents who utilize power mobility devices. • Revised the Electric Wheelchair Use process to require: o Documented nursing assessment upon admission. o Therapy evaluation when safety concerns arise. o Reassessment following accidents, near misses, unsafe driving behaviors, resident complaints, or resident-to-resident incidents. o Documentation of findings and interventions. • Implemented an interdisciplinary review process for any resident involved in a mobility-related accident, resident-to-resident altercation, or unsafe operation of mobility equipment. • Established a behavior monitoring and communication process to ensure all departments, including agency and contract staff, are aware of residents requiring enhanced observation, supervision, or behavioral interventions. • Revised care planning procedures to ensure incidents involving mobility equipment trigger prompt care plan review and intervention updates. • Reinforced staff responsibility to immediately report safety concerns, near misses, and resident-to-resident incidents to nursing leadership.	

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=0689 3S = D	Continued from page 43 and hearing loss. His 1/28/26 care plan indicated that he used a self-propelled manual wheelchair with anti-tip bars and an anti-rollback device, and the staff assisted him with his mobility as needed due to his cognitive decline. On 4/23/26, the staff added interventions after he demonstrated increased evening and nighttime restlessness, agitation, and confusion. The staff were directed to maintain a consistent daily routine, approach him calmly, provide a quiet, low-stimulation environment, offer reassurance and reorientation, use distraction and soothing activities, promote comfort measures, observe and report behavior changes and triggers and encourage social interaction. His 6/22/26 progress note indicated that he was attempting to hit the staff when resident 19 drove by in his power wheelchair, and the two residents hit each other. RN P stepped in between the residents, and the hitting stopped. Resident 5 remained agitated and wandered the facility but did not hit anyone else. His 8/19/26 progress notes indicated that his wheelchair was hit by resident 19, but he did not have any redness, bruising, or skin issues identified from that incident. His family member was notified of the incident and did not want local law enforcement called. On 8/20/26, his physician was notified of the 8/19/26 incident and suggested the facility report the incident to adult protective services. 4. Interview on 9/8/26 at 1:41 p.m. with resident 19 regarding the incident on 8/19/26 revealed that he stated he had "tapped" resident 5's wheelchair and then DON B told him she was going to file a report with "the state." He said he didn't intend to hurt resident 5, but "if I wanted to hurt him, I would have." 5. Interview on 9/9/26 at 10:35 a.m. with Physical Therapy Assistant (PTA) EE revealed that power wheelchair assessments were completed for newly admitted residents with physician orders for physical therapy or as needed if there were concerns such as accidents, bumping into things or people, or increased falls. Resident 19 did not have a physician's order for physical therapy on admission and the provider did not have an assessment completed by the physical therapy department on his admission. 6. Interview on 9/9/26 at 2:40 p.m. with DON B revealed that restorative RN F assessed the use of	F0689	4. The Director of Nursing, Restorative Nurse, Therapy Director, Administrator, or designee will conduct: Power Wheelchair and Mobility Device Audits • Weekly audits of all residents utilizing power mobility devices for four weeks. • Monthly audits for two additional months. Audits will verify: • Completion of required assessments. • Safe operation of mobility equipment. • Appropriate supervision and interventions. • Timely reassessment following incidents or changes in condition. Accident and Incident Audits • Weekly review of all accident reports, near misses, and resident-to-resident incidents for four weeks. • Monthly review for two additional months. Audits will verify: • Appropriate investigation. • Timely implementation of interventions. • Care plan updates. • Therapy referrals and assessments when indicated. Care Plan Audits • Weekly audit of five residents with identified safety risks for four weeks. • Monthly audit of five residents for two additional months. Audits will verify that interventions are individualized, communicated to staff, and effectively implemented. The Administrator/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0689 SS = D	Continued from page 44 the power wheelchair when she walked through the facility with the resident on admission. This was not a formal assessment and was not documented. A re-assessment would be completed if the resident was bumping into the walls, being unsafe, using unsafe speeds, or had a change in cognition. A formal power wheelchair assessment was only done by physical therapy. She did not think a power wheelchair assessment needed to be completed for resident 19 because he intentionally hit resident 5. The leadership team, which included administrator A, DON B, SSD I, activities coordinator S, and restorative RN F, and MDS RN E, discussed his power wheelchair use, but they did not want to infringe on his rights. Restorative RN F updated the care plans, but everyone in the facility was supposed to monitor resident 19 and be aware of what resident 19 was saying and doing. She did not identify any other residents in the facility that resident 19 had concerns about. She was aware of the 7/13/26 incident between residents 5 and 19. She watched the camera video footage, but nothing further was done for that incident because the two residents did not make contact. 7. Interview on 9/9/26 at 4:09 p.m. with restorative RN F revealed that if someone was admitted into the facility with a power wheelchair, they were usually assessed prior to admission. RN F said she would then walk around the facility with the resident in their power wheelchair to assess whether the resident had any visual issues or control issues when using the power wheelchair. If they did, she would have therapy work with them on safety. Her assessment was not documented. No additional assessments were done for power wheelchairs. She expected interventions to be added to the care plan after the July incident with resident 5 and resident 19. She said each care plan should include closer monitoring for each resident. She was not aware of the June incident. 8. Interview on 9/9/26 at 4:15 p.m. with CNA H regarding the 7/13/26 incident with residents 5 and 19 revealed that she and CNA AA were in the hallway by the CNA charting station when resident 5 started grabbing and getting aggressive with them and not wanting to let go of their hands. CNA H then saw resident 19 coming out of his room in his power wheelchair saying, "don't hit women." CNA H said she could tell that resident 19 was going to hit resident 5's wheelchair with his power wheelchair because of how fast he was driving it. CNA H then stood between the two residents, and resident 19	F0689		

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F0689 SS = D	Continued from page 45 stopped his power wheelchair before hitting her with it. 9. Interview and review of the 7/13/26 video footage of resident 19 and 5's incident on 7/13/26 at 4:49 p.m. with ESD BB revealed that around 6:00 p.m., resident 5 was grabbing at CNA AA. CNA H then saw resident 19 come out of his room, pointing, and appeared to be talking. CNA H then got up from where she was seated and stepped between resident 19 and resident 5's wheelchair. Resident 19 then left and went down the hallway. No contact was made at that time. 10. Review of the provider's undated Electric Wheelchair Use policy and procedure revealed "Purpose to establish standardized procedures for assessing, approving, and monitoring resident use of electric wheelchairs to ensure safety for the resident, other residents, visitors, and staff within the facility. Residents who arrive with an electric wheelchair will be assessed by nursing during the admission tour. Safety is the priority. The facility reserves the right to restrict or discontinue electric wheelchair use if operation becomes unsafe. Residents who arrive with an electric wheelchair 1. Initial nursing assessment during admission tour. A licensed nurse will observe the resident operating their electric wheelchair during the admission tour or intake process. The nurse will assess: ability to start/stop safely, ability to navigate hallways, turn, and doorways, awareness of surroundings and pedestrians, speed control, and ability to follow safety instructions. The nurse will document the assessment in the medical record. If safety concerns are identified, the resident will be restricted from independent use until therapy completes a formal evaluation. Nursing and therapy staff will monitor for changes in cognition, strength, or safety awareness. If decline is noted, the wheelchair may be temporarily restricted pending re-evaluation. Residents must follow facility safety rules. Unsafe operation may result in temporary or permanent restriction. Nursing conducts the initial observation and provides ongoing monitoring for changes in functional status or any emerging safety concerns.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and	F0695		

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F0695 SS = D	Continued from page 46 tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that proper infection control practices were followed for the cleaning and storage of oxygen equipment for one of two sampled residents (35) who required the use of a Continuous Positive Airway Pressure (CPAP) machine (a device that uses air pressure to keep breathing airways open) and a nebulizer machine (a device that converts liquid medication into an inhalable mist). Findings Include: 1. Observation and interview on 9/8/26 at 9:55 a.m. with resident 35 in her room revealed that she used a CPAP machine when she slept. The CPAP mask was attached to the machine and was hanging from her bedside table. She stated she did not think her CPAP machine had been cleaned since she admitted to the facility several months ago because she did not have the supplies to clean it. Resident 35 also used a nebulizer machine. The mouthpiece was attached to the nebulizer machine and was on her bedside table. She stated that the staff brought in the nebulizer medication at least twice daily, and she completed the nebulizer treatment and she would shut the machine off. She thought that the nursing staff cleaned the nebulizer mouthpiece each night. Two one-gallon containers of distilled water were on the floor near her plant watering can. One was unopened, and the other was opened and undated. She stated that it was the water used in her CPAP and she did not use it to water her plants. 2. Observation on 9/9/26 at 3:45 p.m. in resident 35's room revealed her CPAP mask was attached to the machine and was placed on top of the CPAP machine, which was on her bedside table. The mouthpiece was attached to the nebulizer machine and was on her bedside table between the CPAP machine and the nebulizer machine.	F0695		

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=0695 SS = D	Continued from page 47 3. Review of resident 35's electronic medical record (EMR) revealed that she admitted to the facility on 4/29/26. Her diagnoses included chronic obstructive pulmonary disease (COPD a group of lung diseases that block airflow and make it difficult to breathe), bronchiectasis (a chronic lung condition where the airways become abnormally widened, thickened, and scarred), pulmonary hypertension (high blood pressure in the arteries that carry blood from your heart to your lungs), shortness of breath, congestive heart failure (a chronic medical condition where the heart muscle cannot pump blood efficiently enough to supply the body with the oxygen and nutrients it needs), and obstructive sleep apnea (a sleep disorder where the muscles in the throat relax too much during sleep, causing the airway to narrow or completely block airflow). Her 8/4/26 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated her cognition was intact. She had a 6/10/26 physician's order for "CPAP one time a day related to obstructive sleep apnea." She had a 4/29/26 physician's order for Albuterol Sulfate Inhalation Nebulization Solution 2.5 mg (milligrams)/3mL (milliliters) 0.083% (percent) (Albuterol Sulfate) to be administered orally via nebulizer every four hours as needed for wheezing related to chronic obstructive pulmonary disease. She had a 5/11/26 physician's order for Arformoterol Tartrate Inhalation Nebulization Solution 15 mcg (micrograms)/2mL to be administered orally via a nebulizer once daily for shortness of breath at 7:00 a.m. She had a 5/11/26 physician's order for "Arformoterol Tartrate Inhalation Nebulization Solution 15 mcg/2mL to be administered orally via a nebulizer once daily for shortness of breath at 4:30 p.m. She had a 5/11/26 physician's order for Budesonide Inhalation Suspension 0.5 mg/2mL to be administered orally via a nebulizer once daily for COPD at 7:00 a.m., with instructions to "RINSE MOUTH after each use." She had a 5/11/26 physician's order for Budesonide Inhalation Suspension 0.5 MG/2ML. Administer 2 mL orally via nebulizer once daily related to COPD at 4:30 p.m., with instructions to "RINSE MOUTH after each use." 4. Observation and interview on 9/9/26 at 4:17 p.m.	F0695	1. Resident #35 was assessed regarding the cleaning, maintenance, and storage of her CPAP and nebulizer equipment. The resident's CPAP mask, tubing, humidification chamber, and nebulizer equipment were inspected, cleaned, disinfected as appropriate, and replaced as indicated. A designated storage container was provided for nebulizer equipment. Distilled water containers were dated upon opening and relocated to an appropriate storage location. The physician was notified of the findings. The resident and family were educated regarding proper handling, storage, and cleaning requirements for CPAP and nebulizer equipment. Nursing staff were re-educated regarding infection control requirements, proper hand hygiene, cleaning procedures, storage expectations, and documentation requirements for respiratory equipment. Resident #35's care plan was reviewed and updated to include CPAP maintenance, nebulizer cleaning procedures, equipment storage requirements, and resident-specific respiratory care interventions 2.The Director of Nursing, Infection Preventionist, and Designee completed a 100% audit of all residents utilizing: · CPAP devices · BiPAP devices · Nebulizer equipment · Oxygen concentrators · Other reusable respiratory equipment The audit included review of: · Equipment cleaning practices. · Storage methods. · Documentation of required cleaning and maintenance. · Availability of required supplies. · Resident care plans. · Physician orders related to respiratory equipment. · Infection control practices. Any identified concerns were immediately corrected.	October 6, 2026

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F0695 SS = D	Continued from page 48 with resident 35 and her sister in resident 35's room revealed that resident 35's CPAP mask and nebulizer mouthpiece were on the bedside table attached to the respective machines. Resident 35 stated her CPAP mask did not fit well, and her sister made an appointment to have it checked. Resident 35 and her sister did not know when the CPAP mask or the nebulizer mouthpiece were last cleaned or who was responsible for cleaning them. Resident 35 said, "It is usually just here on my table." 5. Observation and interview on 9/9/26 from 4:18 p.m. through 4:36 p.m. with contracted travel licensed practical nurse (LPN) HH revealed that she entered resident 35's room to administer resident 35's nebulizer treatment. Resident 35 handed LPN HH the nebulizer mouthpiece attached to the nebulizer machine. LPN HH asked resident 35 where the "wiggly part" of her nebulizer mouthpiece was. Resident 35 stated it did not come with one. Resident 35 took the mouthpiece apart and set the pieces on the arm of her recliner. LPN HH stated that she was going to look for a "new set," and left the room. When LPN HH returned to the room, she said that the "new kits don't come with a flapper. LPN HH, without completing hand hygiene (hand washing or the use of hand sanitizer), put on a pair of gloves. Resident 35 picked up the nebulizer pieces and handed them to LPN HH. LPN HH put the nebulizer medication in the well of the mouthpiece and reassembled it, handed the mouthpiece to resident 35, turned on the machine, stated that she would return in fifteen minutes, and left the room. At 4:20 p.m., LPN HH continued to assist other residents in that hallway and in their rooms. At 4:29 p.m., resident 35 turned off her nebulizer machine. At 4:36 p.m., LPN HH returned to resident 35's room as resident 35 and her sister exited the room. LPN HH asked resident 35 if she had finished her nebulizer treatment. Resident 35 indicated that she had. LPN HH took resident 35's nebulizer mouthpiece into the shared bathroom, placed the mouthpiece on the washcloth that was located on the left side of the sink, without completing hand hygiene, put on a pair of gloves, rinsed the mouthpiece, then placed the mouthpiece on two wet paper towels on resident 35's small dresser. LPN HH stated that she planned to clean the mouthpiece with warm, soapy water after resident 35 received her last nebulizer treatment for the day. LPN HH did not know when resident 35's CPAP machine would be cleaned because she worked the evening shift and assisted resident 35 with putting the machine on, not taking it off, in the morning.	F0695	3. The facility implemented the following systemic changes: • Re-educated all licensed nurses, medication aides, nursing assistants, agency staff, and contract staff regarding: o F695 respiratory care requirements. o Infection prevention and control practices. o Proper hand hygiene before handling respiratory equipment. o Cleaning and maintenance of CPAP, BiPAP, and nebulizer equipment. o Appropriate drying and storage procedures. o Documentation requirements. o Manufacturer recommendations and facility policies. • Implemented a standardized respiratory equipment cleaning protocol that includes: o Daily and weekly cleaning responsibilities. o Required documentation of completed cleaning. o Proper equipment storage procedures. o Dating of distilled water containers when opened. o Appropriate storage of distilled water supplies. • Created a respiratory equipment checklist for residents using CPAP, BiPAP, or nebulizer therapy. • Implemented supervisory review to ensure cleaning and maintenance documentation is completed as required. • Added respiratory equipment care review to admission, care plan, and quarterly review processes. • Ensured all residents requiring respiratory equipment have appropriate supplies available to support required cleaning and infection prevention practices.	

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F0695 SS = D	Continued from page 49 LPN HH stated that resident 35 was able to administer her own nebulizer treatment and that the mouthpiece was usually on resident 35's nightstand and attached to the nebulizer machine when she brought the nebulizer medication into resident 35's room because resident 35 was able to turn the machine off on her own. 6. Interview on 9/10/26 at 9:05 a.m. with registered nurse (RN) J revealed she expected each resident to have a plastic bowl in their closet where the nebulizer mouthpiece would be stored between uses. She expected staff to rinse the nebulizer mouthpiece after each use and wash it with warm, soapy water at the end of the day. The wet mouthpiece pieces were set to dry on paper towels in the bowl and were stored in the resident's closet. She expected that staff would complete hand hygiene before putting on gloves to handle the resident's nebulizer mouthpiece to prevent contamination. 7. Interview and review of resident 35's EMR on 9/10/26 at 9:15 a.m. with certified medication aide (CMA) II revealed that she administered resident 35's nebulizer treatment that morning. She did not stay with resident 35 when she completed her nebulizer treatments because she was told resident 35 was able to self-administer those treatments. She thought that resident 35 removed her own CPAP mask before she arrived to work that morning because resident 35 was not wearing it when she was in her room. She did not clean resident 35's CPAP mask or her nebulizer mouthpiece and thought those tasks were completed on the evening shift. CMA II reviewed resident 35's EMR and was unable to find documentation that her CPAP and nebulizer mouthpiece were cleaned. CMA II asked the surveyor to speak with director of nursing (DON) B. 8. Observation, interview, and EMR review on 9/10/26 at 1:51 p.m. with DON B revealed that she expected documentation in resident 35's treatment administration record (TAR) to indicate when resident 35's CPAP mask was cleaned. She confirmed that no documentation showed resident 35's CPAP mask had been cleaned since resident 35 admitted to the facility in April 2026, but she thought resident 35 had not been wearing her CPAP. DON B expected staff to clean resident 35's CPAP weekly. DON B expected staff to rinse the nebulizer	F0695	4. The Director of Nursing, or designee will complete the following audits: Respiratory Equipment Audits • Weekly audits of all residents utilizing CPAP, BiPAP, nebulizer, or other respiratory equipment for four weeks. • Monthly audits for two additional months. Audits will verify: • Equipment cleanliness. • Proper storage practices. • Availability of required supplies. • Appropriate dating and storage of distilled water. • Compliance with facility policies. • Completion of required documentation. Infection Control Observation Audits • Weekly observation of five respiratory equipment procedures for four weeks. • Monthly observation for two additional months. Audits will verify: • Proper hand hygiene. • Appropriate glove use. • Correct cleaning procedures. • Proper drying and storage techniques. • Compliance with infection prevention standards. Documentation Audits • Weekly review of respiratory equipment maintenance records for four weeks. • Monthly review for two additional months. The DON/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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F0695 SS = D	Continued from page 50 mouthpiece after each use, wash it with warm, soapy water at the end of the day, and store it on paper towels in a bowl in resident 35's closet. She confirmed that resident 35 did not have a plastic bowl to store her nebulizer mouthpiece between uses. DON B confirmed that the two one-gallon containers of distilled water on resident 35's floor were used for filling resident 35's CPAP and that the opened container was not dated when it was opened. She expected those gallon containers to be stored in resident 35's closet and dated when they were opened. Review of resident 35's TAR revealed resident 35 wore her CPAP intermittently in April, May, and June 2026, twenty-two times in August 2026, and each night in September 2026. 9. Review of the provider's May 2025 Cleaning a Nebulizer policy revealed that the purpose was to "prevent the growth of bacteria on [the] nebulizer equipment." Equipment needed included a bowl, a clean barrier, mild dish soap, and a "sink to wash [the nebulizer] in." "Procedure after each use: 1. Remove the tubing from the mask or mouthpiece and aerosolized cup [the small plastic container that holds liquid medicine and turns it into a fine mist for inhalation]. 2. Rinse with warm tap water between each medication. 3. Allow to air dry on [the] clean barrier in [the] bowl." "Procedure at [the] end of [the] day: 1. Remove the tubing from the mask or mouthpiece and aerosolized cup. 2. Disassemble the pieces and wash them in warm, soapy water. 3. Rinse under a steady stream of warm water. 4. Allow to air dry on a clean barrier in the bowl; place in the bottom drawer of the bathroom or in the resident['s] closet..." 10. Review of the provider's revised September 2026 C-Pap/BI-Pap Maintenance policy revealed that its purpose was to provide guidelines for cleaning and maintaining the C-Pap/Bi-Pap machine. The policy indicated, "Clean the mask with a damp cloth and empty the water chamber daily." Weekly cleaning included "clean the filter on the back of the machine," "clean the tubing weekly," "wipe the outside of the machine with a cloth slightly dampened with water and a mild detergent, and "soak the water chamber of the machine in 1:3 [one	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	**1001 S EGAN AVE , MADISON, South Dakota, 57042**

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=0695 SS = D	Continued from page 51 part to three parts] water/vinegar solution for 30 minutes every week. Rinse and allow to air dry."	F0695		
=0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, and policy review, the provider failed ensure accurate accountability of one of one liquid controlled medication. Findings include: 1. Review of the provider's 9/7/26 SD DOH FRI revealed that on 9/5/26 at approximately 9:00 a.m. during the shift-to-shift narcotic count, a	F0755	1. An immediate piece-by-piece physical inventory audit of all controlled substance storage areas (medication carts, automated dispensing units, and back-up supply) was conducted by the MDS Coordinator and RN Staff Education Nurse on 9/5/26. The individual Controlled Substance Administration Records (CSAR) and Electronic Medication Administration Records (eMAR) for all residents receiving Schedule IV medications were cross-referenced against physical count sheets to identify precise timeline gaps conducted by the MDS Coordinator on 9/5/26. Initial notifications were submitted to the South Dakota Department of Health on 9/7/2026, local law enforcement on 9/7/2026 to Officer Talik Police Report 26-000377 and the South Dakota Board of Nursing on 9/8/26. The Medical Director and Consulting Pharmacy were notified on 9/8/2026. 2. All residents receiving scheduled/controlled medications were determined to have the potential to be affected by this practice. A 100% audit of all controlled substance count sheets and administration logs across all medication carts and units was completed on 9/5/2026 by the MDS Coordinator and RN Staff Education to ensure no other missing doses or unverified signature lines existed. Audits will verify that two physical signatures are present for every individual line item on the perpetual inventory log during shift transfers.	

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F0755 SS = D	Continued from page 52 discrepancy between the medication control log and the remaining amount of liquid Lorazepam (controlled medication used to treat anxiety and seizures) for resident 7 was noted by contracted travel licensed practical nurse (LPN) M. Both administrator A and director of nursing (DON) B were notified of the discrepancy by phone. Minimum data set (MDS) coordinator/registered nurse (RN) E and restorative RN F were called to the facility to reconcile the medication. The reconciliation verified that 6.25 milliliters (ml) was missing, equaling approximately 25 doses of medication. The investigation was still ongoing. 2. Interview on 9/10/26 at 12:00 p.m. with MDS coordinator/RN E revealed that she was called to reconcile the missing medication on 9/5/26. She recalled that RN LL was the nurse going off her shift and contracted travel LPN M was beginning her shift and LPN M noticed a discrepancy with the Lorazepam. LPN M reported that RN LL had left the facility before MDS/RN E arrived at the facility. MDS/RN E reported that when a discrepancy like that was discovered, both staff involved should have remained in the facility until the discrepancy was resolved. 3. Observation and interview on 9/9/26 at 2:17 p.m. in the medication room with LPN K revealed resident 7 had an amber colored glass bottle of Lorazepam in the locked medication refrigerator. The bottle had no markings to measure the liquid until the label began, and the first marked measurement on the bottle was 22 milliliters (mL). LPN K said only two nurses on the floor had a key to the medication refrigerator. 4. Interview and review of the controlled narcotic form on 9/9/26 at 2:51 p.m. with LPN K revealed the controlled narcotic form indicated that resident 7's bottle of Lorazepam had 29.5 mL of medication left in the bottle. LPN K said he did not confirm the amount of medication within the bottle by measuring it, but he knew by experience and looking at the bottle how much was in it. He then referred to the director of nursing (DON) B to find out the process for measuring controlled liquid medications. 5. Interview on 9/9/26 at 2:53 p.m. with DON B revealed that the staff did not count the Lorazepam, and there was not a process for it at that time. 6. Observation and interview on 9/10/26 at 12:35 p.m. revealed that LPN K and RN J removed the Lorazepam from the locked fridge in the medication room. RN J was disposing of the Lorazepam. She	F0755	3. Policy Update: The facility's Controlled Substance Policy was revised to explicitly mandate that both incoming and outgoing nurses must independently conduct a line-by-line physical count of every individual controlled medication container and jointly sign each corresponding line on the controlled substance log at every shift change. Shift-Change Protocol: "Blanket" signing or delegating count verification without physical line-item inspection is strictly prohibited. Medication aides (UAPs) are prohibited from co-signing or verifying shift counts without a licensed nurse (RN/LPN) participating in the count. Staff Retraining: Mandatory in-service training was initiated for all licensed nursing staff (RNs and LPNs) on proper chain-of-custody documentation, dual-signature requirements, and immediate discrepancy reporting. Any nurse failing to complete training by September 9. 2026 will be removed from the schedule until compliant. 4. Quality Assurance & Monitoring Plan The DON, Staff Development Coordinator, or RN Designee will conduct random shift-change count audits 5 times per week for 4 weeks, then 3 times per week for 4 weeks, and monthly thereafter for 4 months. Audits will verify that two physical signatures are present for every individual line item on the perpetual inventory log during shift transfers. The DON/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	October 6, 2026

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=0755 SS = D	Continued from page 53 used a measuring cup to measure 30 mL and disposed of it in the RX destroyer. She then used water in the medication cup and medication bottle and added it to the RX destroyer. Both LPN K and RN J signed the controlled substance form verifying that 30 mL was disposed of. LPN K said it had to be two nurses destroying controlled substances. If there was a discrepancy, they would look at the medication administration record (MAR) and try to identify it. If not, they would notify DON B as soon as possible. 7. Review of LPN M's 9/5/26 written statement regarding the medication discrepancy revealed that while doing the shift-to-shift narcotic count, she noticed that there should have been 22.75 ml of Lorazepam in the bottle, but there was only approximately 16 ml. LPN M reported that she told RN LL that she was not comfortable signing off an incorrect narcotic count and was ignored by RN LL. RN LL responded that she had told LPN MM about the discrepancy at another time and that management was aware of it. RN LL then left the facility before the discrepancy was resolved. 8. Interview on 9/10/25 at 1:55 p.m. with administrator A revealed that after the incident occurred, she had MDS/RN E and restorative RN F reconcile the medication. After the reconciliation was completed, administrator A then secured the medication in a locked cabinet in her office. She then notified the police of the missing medication. Administrator A reported that while conducting staff interviews, RN LL was questioned about why she left the facility before resolving the discrepancy, and RN LL's response was that she had previously told LPN MM and LPN K about the discrepancy. When administrator A informed RN LL that she would be suspended pending further investigation, she responded that she would give her two weeks notice to end her employment. 9. Interview on 9/10/26 at 2:45 p.m. with LPN K regarding RN LL's statement that he had been made aware of the lorazepam discrepancy before 9/5/26, he responded "she absolutely did not tell me about any discrepancy." He reported that if she had told him, he would have documented the discrepancy and notified DON B. 10. Phone interview on 9/10/26 at 5:25 p.m. with LPN MM regarding RN LL's statement that she had been made aware of the lorazepam discrepancy before 9/5/26 she responded that RN LL had never made her aware of any discrepancy.	F0755		

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F0755 SS = D	Continued from page 54 11. Review of the provider's undated Discrepancy protocol revealed "If a discrepancy occurs (e.g., missing doses, unmatched signatures, broken seals): Do NOT transfer keys or complete shift turnover. The outgoing nurse cannot leave the facility until the discrepancy is resolved or formally reported.	F0755		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 9/8/26. Bethel Lutheran Home was found in compliance.	E0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Holland	Administrator	09/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/08/2026

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/8/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethel Lutheran Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K211, K321, and K351 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	1. Because the cited deficiency involved the building fire protection system, all residents, staff, and visitors within the facility had the potential to be affected. Upon identification of the deficiency: The open areas surrounding the return air vent in the corridor outside the north dayroom were corrected to eliminate access to the concealed space above the ceiling and restore the integrity of the sprinkler system design. The missing ceiling tile in the records room was replaced. The missing ceiling tile in the sitting area across from the nurse station was replaced. The Maintenance Supervisor inspected the affected areas to verify that openings into concealed spaces were eliminated and that the sprinkler system protection was maintained as designed. The Administrator and Maintenance Supervisor verified that the identified deficiencies were corrected and that heat and products of combustion could not bypass the sprinkler-protected area through the cited openings. 2. The Maintenance Supervisor and Maintenance Assistant conducted a facility-wide inspection of all resident care areas, common areas, storage areas, offices, mechanical spaces, and service areas to identify: Missing ceiling tiles. Damaged ceiling tiles. Openings into concealed ceiling spaces. Unprotected areas that may affect sprinkler system performance. Return air vents with exposed concealed spaces. Areas where contractor or maintenance work may have impacted ceiling integrity. Any concerns identified during the facility-wide inspection were corrected immediately.	October 6, 2026
K0351 SS = E Bldg. 01	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure the building was protected throughout by an approved automatic sprinkler	K0351		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 10 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Holland	Administrator	9/29/2026

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K0351 SS = E Bldg. 01	Continued from page 1 system at three randomly observed locations (corridor outside the north dayroom, the records room, and the sitting area by the nurse's station) 1. Observation beginning on 9/8/26 at 12:15 p.m. revealed a return air vent in the ceiling of the corridor outside the north dayroom. That return air vent was located above the lay-in ceiling and terminated at the ceiling level with eggcrate louvers. Those eggcrate louvers left an open area to the concealed space above the lay-in ceiling of approximately 1-foot two-inches on both the north and south sides of the vent. The openings into the concealed space above created an area not provided sprinkler coverage in that corridor. Those openings would allow the heat and products of combustion to bypass the building's sprinkler system preventing it from operating within its original design. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He was unaware those openings were present in that location. He also believed those openings in that location predated his employment at the facility. 2. Observation beginning on 9/8/26 at 12:47 p.m. revealed a missing ceiling tile in the records room. That missing ceiling tile created a concealed space above and an area not provided sprinkler coverage in that room. That opening would allow the heat and products of combustion to bypass the building's sprinkler system preventing it from operating within its original design. Interview with the maintenance supervisor at the time of the observations confirmed that finding. He believed that ceiling tile had been removed for a plumber to access the facility's plumbing in that location, and that he was unaware the ceiling tile was missing in that location. 3. Observation beginning on 9/8/26 at 1:13 p.m. revealed a missing ceiling tile in the sitting area located across from the nurse station.That missing ceiling tile created a concealed space above and an area not provided sprinkler coverage in that room. That opening would allow the heat and products of combustion to bypass the building's sprinkler system preventing it from operating within its original design. Interview with the maintenance supervisor at the time of the observations confirmed that finding. He was above the ceiling in that location and thought he had replaced the tile.	K0351	3. The facility implemented the following systemic changes: Re-educated the Maintenance Supervisor and maintenance personnel regarding Life Safety Code requirements related to sprinkler protection and ceiling system integrity. Implemented a monthly Life Safety inspection checklist that includes: Verification that all ceiling tiles are in place. Inspection for openings into concealed ceiling spaces. Inspection of return air vents and ceiling penetrations. Inspection of areas where maintenance, plumbing, HVAC, or contractor work has been performed. Implemented a process requiring maintenance staff to inspect and restore ceiling systems immediately following any work above the ceiling. Implemented a contractor oversight process requiring maintenance staff to verify all ceiling tiles and fire protection components are restored upon completion of contractor work. Added ceiling system and sprinkler protection inspections to routine environmental and safety rounds. 4. The Maintenance Supervisor, Administrator, or designee will conduct: Weekly Audits for Four Weeks and monthly audits for two additional months The audits will verify: Ceiling tiles are present and properly installed. No openings exist into concealed ceiling spaces. Return air vents are properly enclosed. Sprinkler system coverage has not been compromised. Contractor and maintenance work areas have been restored appropriately. The Maintenance Supervisor will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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K0211 SS = D Bldg. 01	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain egress doors free of all obstructions to full use in case of emergency as required at one randomly observed exit door location (south exit of activities/chapel suite). Findings include: 1. Observation beginning on 9/8/26 at 12:53 p.m. revealed the east leaf of the south exit door out of the activities/chapel suite was unable to be fully opened. Testing of that door leaf revealed it would open, but would hit an entertainment stand in the corridor to the north beyond it. That entertainment stand reduced the swing of that door by approximately 40%. Interview at the time of the above observation with the maintenance supervisor confirmed that condition. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants.	K0211	1. Because the identified exit door serves the Activities/ Chapel Suite and is part of the facility's means of egress, all residents, visitors, and staff utilizing that smoke compartment had the potential to be affected by the deficient practice. The entertainment stand obstructing the east leaf of the south exit door from the Activities/Chapel Suite was immediately removed. The door was tested and verified to open fully and unobstructed. The Maintenance Supervisor verified proper operation of the exit door. 2. The Maintenance Supervisor and Administrator conducted a facility-wide inspection of all exit doors, smoke barrier doors, corridors, and means of egress to identify any obstructions affecting door swing or evacuation routes. Any concerns identified during the inspection were corrected immediatel. 3. Staff were educated regarding maintaining unobstructed exits and evacuation routes. Monthly Life Safety rounds were implemented to verify exit doors open fully and egress pathways remain clear. Environmental and safety rounds now include inspection of exit doors and corridor obstructions. Staff are required to immediately report any obstruction affecting exit access or door operation. 4.The Maintenance Supervisor, Administrator, or designee will: Conduct weekly audits of all exit doors and egress routes for four weeks. Conduct monthly audits for two additional months. Verify that exit doors open fully, egress pathways remain clear, and no furniture or equipment obstructs evacuation routes. The Maintenance Supervisor/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	October 6, 2026
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and	K0321		

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Bethel Lutheran Home	1001 S EGAN AVE , MADISON, South Dakota, 57042

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K0321 SS = D Bldg. 01	Continued from page 3 doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain one hazardous area (food storage/housekeeping) as required. Findings include: 1. Observation and testing on 9/8/26 at 12:25 p.m. revealed the food storage/housekeeping room was over 100 square feet and contained combustible items. The door from the housekeeping half of the room to the corridor was held open with a bungee cord. That room was considered a hazardous area and that door was required to automatically latch into the door frame. That bungee cord would interfere with the closing of that door in the event of a fire. Interview with the maintenance supervisor at the	K0321	**K0321** 1.Because the identified food storage/housekeeping room is located within the facility and serves an area occupied by residents, all residents within the affected smoke compartment had the potential to be affected by the deficient practice . Upon identification of the deficiency, the bungee cord being used to hold open the hazardous area door was immediately removed. The door was tested and verified to self-close and positively latch into the door frame as designed. The Maintenance Supervisor inspected the door assembly to confirm proper operation and compliance with Life Safety Code requirements. The hazardous area was reviewed to ensure all protective features were functioning properly and that no other devices were obstructing the automatic closing and latching of the door. The Maintenance Supervisor and Maintenance Assistant conducted a facility-wide inspection of all hazardous areas, including but not limited to: • Housekeeping rooms • Storage rooms • Laundry areas • Mechanical rooms • Soiled utility rooms • Food storage areas The inspection included verification that: • Hazardous area doors were not blocked or held open improperly. • Doors self-closed and positively latched. • Door hardware functioned correctly. • No unauthorized devices were used to prevent doors from closing. Any concerns identified during the inspection were corrected immediately. 2. The Maintenance Supervisor and Maintenance Assistant conducted a facility-wide inspection of all hazardous areas, including but not limited to: • Housekeeping rooms • Storage rooms • Laundry areas • Mechanical rooms • Soiled utility rooms • Food storage areas The inspection included verification that: • Hazardous area doors were not blocked or held open improperly. • Doors self-closed and positively latched. • Door hardware functioned correctly. • No unauthorized devices were used to prevent doors from closing. Any concerns identified during the inspection were corrected immediately.	October 6, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435076	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 09/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	1001 S EGAN AVE , MADISON, South Dakota, 57042

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K0321 SS = D Bldg. 01	Continued from page 4 time of the observations confirmed those findings.	K0321	3. The facility implemented the following systemic changes: • Re-educated maintenance personnel, housekeeping staff, dietary staff, nursing staff, and department managers regarding Life Safety Code requirements for hazardous area doors. • Reinforced that hazardous area doors may not be propped open or secured open by unauthorized devices, including bungee cords, wedges, furniture, or other means. • Implemented monthly Life Safety inspections that include: o Verification that hazardous area doors self-close and latch properly. o Inspection for unauthorized devices holding doors open. o Inspection of door hardware and functionality. • Added hazardous area door inspections to routine environmental and safety rounds. • Established expectations that staff immediately report any door that does not properly self-close and latch. 4.The Maintenance Supervisor, Administrator, or designee will conduct audits as follows: • Weekly inspections of all hazardous area doors for four weeks. • Monthly inspections for two additional months. Audits will verify: • Doors are not propped open. • Doors self-close properly. • Doors positively latch into the frame. • Door hardware functions correctly. • No unauthorized devices are present. • Corrective actions are implemented immediately when concerns are identified. The Maintenance Supervisor/designee will bring audit findings to be reviewed monthly through the Quality Assurance and Performance Improvement (QAPI) Committee. Any identified concerns will result in immediate corrective action, additional education, and continued monitoring until substantial compliance is achieved and sustained. QAPI will make recommendations for continuing, modifying or discontinuing audits.	

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
	10644	A. BUILDING: _____ B. WING _____	09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN HOME	1001 S EGAN AVE MADISON, SD 57042

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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 9/8/26 through 9/10/26. Bethel Lutheran Home was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure that one of two dietary aides (DA) (X) reviewed for training completed the required dietary training (Food safety, handwashing, food handling/preparation, foodborne illnesses, serving/distribution, leftovers, time/temperature controls, nutrition/hydration, and sanitation) within 30 days of hire.	S 301	1. Dietary Aide (DA) X's personnel file was reviewed and verified to confirm completion of the required dietary training. Although the required dietary training was completed, it was not completed within 30 days of hire as required by South Dakota Administrative Rule 44:73:07:16. The Dietary Manager and Administrator reviewed DA X's training record and provided education regarding facility orientation and mandatory training requirements. The facility reviewed onboarding procedures to ensure required dietary training is completed within regulatory time frames 2.The Human Resources Director completed a 100% audit of all dietary employees and other food-handling personnel hired within the previous twelve months. The audit verified completion and timeliness of required training in the following areas: Food safety Handwashing Food handling and preparation techniques Food-borne illnesses Serving and distribution procedures Leftover food handling Time and temperature controls Nutrition and hydration Sanitation requirements Any missing or overdue training identified during the audit was completed immediately..	October 6, 2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Katherine Holland	Administrator	09/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10644	A. BUILDING: _____ B. WING _____	09/10/2026

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S 301	Continued From page 1 Findings include: 1. Review of the provider's employee personnel records for DA X revealed that she was hired on 4/6/26. She completed the required dietary training on 6/30/26. Those trainings were not completed within 30 days of her hire date. 2. Interview on 9/10/25 at 4:10 p.m. with administrator A revealed that she confirmed DA X did not complete the required dietary training within 30 days of her hire date.	S 301	3. The facility implemented the following systemic changes: Revised the dietary orientation process to include all required dietary training as a part of the on-boarding process completed at the time of hire. 4. The Human Resources Director will conduct: Weekly audits for four weeks and monthly for two months. The audits will review: Newly hired dietary employees. Completion of required dietary training. Timeliness of training completion. Documentation of completed education. Monthly Audits for Two Additional Months The HR Director/designee will bring audit findings monthly for review at the Quality Assurance and Performance Improvement (QAPI) Committee. QAPI will make recommendations to increase, decrease or discontinue audits.	