STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/16/25 through 12/18/25. Bethany Home - Brandon was found not in compliance with the following requirements: F554, F578, F584, F658, F689, F695, 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 12/16/25 through12/18/25. The areas surveyed were suspected resident abuse and neglect. Bethany Home - Brandon was found to have past non-compliance with the following requirement: F600.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §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 one of one sampled resident (19), who had a medication pill at his bedside, was assessed for the ability to safely self-administer medications and had a physician's order to self-administer medications according to the provider's policy. Findings include: 1. Observation and interview on 12/16/25 at 4:12 p.m. with resident 19 in his room revealed there was a small white oval pill in a plastic medication cup sitting on his bedside table. The pill had "0164" stamped on one side, and the letter "R" stamped above the number "5" on the other side. Resident 19 said that if he is sleeping, staff would leave his pills on his bedside table so he could take them later. He swallowed the medication at that time with a drink of water.	F0554	On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to resident self-administration of medication. On 01/13/2026, DON, or designee, reviewed all resident's self-administration status orders to ensure they were accurate. Resident 19 discharged from the facility on 12/18/2025. CNA L, NL W, ADON C, DON B, and all staff will be educated via in-service by 02/01/2026 regarding the policies and procedures related to resident self-administration of medication. Beginning 01/19/2026, DON, or designee, will audit medication passes to ensure medications are administered as ordered 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. DON, or designee, will present the findings of the audit to the QAPI committee for review and recommendation.	02/01/2026

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
Hunter Winkleplack	Administrator	01/14/2026

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F0554 SS = D	Continued from page 1 2. Review of resident 19's electronic medical record (EMR) revealed that he was admitted to the facility on 6/12/25. He did not have a physician's order to self-administer any medications. There was no record of medication self-administration assessments. His current care plan did not include any medications that he could self-administer. 3. Interview on 12/17/25 at 10:00 a.m. with certified nursing assistant (CNA) L revealed that she was also a certified medication aide (CMA). Resident 19 was independent with activities of daily living (ADLs) such as getting up from his bed, walking, brushing his teeth, and changing clothes. She did not know if he had an order for medication self-administration. She explained that sometimes, resident 19 would become upset if staff stood there to watch him take his medications. She confirmed that if a resident did not have an order to administer their medications by themselves, staff were to observe the resident take their medications rather than leave the medications with the resident. 4. Interview on 12/17/25 at 10:13 a.m. with neighborhood leader (NL) W revealed that she confirmed that resident 19 did not have an order for medication self-administration. She confirmed that at around the time the pill was found on 12/16, resident 19 would have been given his olanzapine (an atypical antipsychotic medication). NL W unlocked the medication cart and confirmed the small white oval pill with "0164" stamped on one side, and the letter "R" stamped above the number "5" on the other side was resident 19's olanzapine. She expected the licensed nurses and CMAs to watch the resident take their medications if the resident did not have an order to self-administer their medications. She stated that if a resident wanted to self-administer their own medications, the nurse and resident would complete a medication self-administration assessment, contact the physician, and update the resident's orders. Continued interview on 12/17/25 at 10:40 a.m. with NL W revealed that she contacted the nurse who was working on 12/16/25. That nurse said that she thought she saw him take the pill, so she did not know why the pill was still in the medication cup when it was observed by the survey team on 12/16/25 at 4:12 p.m. that day.	F0554		

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F0554 SS = D	Continued from page 2 5. Interview on 12/17/25 at 3:32 p.m. with assistant director of nursing (ADON) C revealed that resident 19's medications should not have been left in his room. The person administering his medications should have observed resident 19 take his medications and ensured that he actually took them. She confirmed that resident 19 had not been assessed to take his medications by himself, and he did not have a physician's order for medication self-administration. 6. Interview on 12/17/25 at 4:00 p.m. with director of nursing (DON) B revealed that if a resident did not have an order for medication self-administration, the staff person administering the medications should be observing the resident take their medications. She confirmed that resident 19 did not have an order to self-administer his medications. She explained that if a resident wished to self-administer their medications, the nurse assessed the resident's cognition and filled out the Self-Administration of Medications form. That form consisted of quizzing the resident on what each medication was, what was it prescribed for, what the potential side effects were, what the dosage was, what route was it to be administered, and what time it should be administered. If the resident could not confidently list each topic for the medication, they could not safely self-administer their own medications. 7. Review of the provider's 1/2025 Self-Administration of Medications policy revealed that the policy interpretation and implementation section contained the following items: "1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident." "2. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration; b. The resident is able to read and understand medication labels; c. The resident can follow directions and tell time to know when to take the medication;	F0554		

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F0554 SS = D	Continued from page 3 d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; and e. The resident is able to safely and securely store the medication." "3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status." "4. If the team determines that a resident cannot safely self-administer medications, the nursing staff [will] administer the resident's medications." "...6. Self-administered medications are stored in a safe and secure place." "7. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party."	F0554		
F0578 SS = E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F0578	On 01/13/2026, residents 9, 44, and all residents code status' were reviewed to ensure they had the proper signatures in place and that the codes status matched the documented directives in the resident's chart. Resident 19 discharged from the facility on 12/18/2025 and resident 59 discharged from the facility on 12/29/2025. On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to resident code status and advanced directives. DON B, SDD F, LPN V, LPN J, NL W, ADON C, and all staff will be educated via in-service by 02/01/2026 regarding the policies and procedures related to code status and advanced directives. Beginning 01/19/2026, the Administrator, or desigee, will audit that newly admitted residents have the proper signatures on their code statuses and that the resident's current code status matches their documented code status in their medical chart 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x 4 weeks. Administrator, or desginee, will present the findings of the audit to the QAPI committee for review and recommendation.	02/01/2026

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F0578 SS = E	Continued from page 4 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to involve five of thirty (4, 9, 19, 44, and 59) sampled residents' primary care provider (PCP) in the development of the resident's advanced directives according to facility policy, failed to update one of five (44) sampled resident's electronic medical record (EMR) after the resident's code status had changed, failed to include one of five (59) sampled resident's code status on their care plan according to facility policy, and failed to make the resident's updated code status form available to direct care staff in the resident's EMR, which created potential confusion for staff when the most updated form was not available. Findings include: 1. Review of resident 4's EMR revealed his code status was "Do Not Resuscitate" (DNR) on the top dashboard. His current care plan indicated his code status was DNR. There was no scanned document of his signed code status form in the "Miscellaneous" section, where scanned documents were stored. There was no documentation found anywhere in the EMR regarding the resident's code status. 2. Review of resident 9's EMR revealed her code status was DNR on the top dashboard. Her current care plan indicated her code status was DNR. There was no scanned document of her signed code status form in the "Miscellaneous" section.	F0578		

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F0578 SS = E	Continued from page 5 3. Review of resident 19's EMR revealed his code status was DNR on the top dashboard. His current care plan indicated his code status was DNR. There was no scanned document of his signed code status form in the "Miscellaneous" section. 4. Review of resident 44's EMR revealed his code status was DNR on the top of the dashboard. His current care plan included an intervention that read, "I am a FULL CODE." That intervention was initiated on 4/24/25 and revised on 11/21/25. The most recent code status form in the "Miscellaneous" section was from 4/25/23, which indicated that resident 44 wished to receive CPR (cardiopulmonary resuscitation) if he was in cardiac arrest (when the heart stops beating). 5. Review of resident 59's EMR revealed her code status was DNR at the top of the dashboard. Her current care plan did not include her code status. There was no scanned document of her signed code status form in the "Miscellaneous" section. 6. Interview on 12/17/25 at 1:56 p.m. with director of nursing (DON) B revealed that social services director (SSD) F was responsible for obtaining the resident's code status upon their admission to the facility. Their process was to have two staff members witness the resident or their representative sign the code status form. Then, SSD F was responsible to send the code status forms to the resident's PCP for review. The resident's PCP was supposed to sign the form and send it back to SSD F. Then, SSD F was supposed to scan the signed resident code status form into the resident's EMR. She provided copies of resident 4, 9, 19, 44, and 59's code status forms, and explained that they were in the "Document Manager" section of the resident's EMR, which was not available for staff or the survey team to review. She explained that none of the resident's code status forms were forwarded to the resident's PCP for review. 7. Review of resident 4, 9, 19, 44, and 59's code status forms revealed that resident 4 signed his DNR choice on 11/18/25, resident 9 signed her DNR choice on 7/3/25, resident 19's representative signed his DNR choice on 6/12/25, resident 44 signed his DNR choice on 10/20/25, and resident 59's representative signed her DNR choice on 12/2/25. There were no PCP signatures on any of the residents' code status forms. 8. Interview on 12/18/25 at 8:43 a.m. with SSD F	F0578		

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F0578 SS = E	Continued from page 6 revealed that at the time of a resident's admission, she had a conversation with the resident or their representative to explain what the advanced directives were, what a full code meant, and what a DNR meant. She typically had a witness present during that conversation, so two staff members witnessed the form being signed by the resident or their representative. They switched to a "Document Manager" electronic form management in their EMR. After the resident or their representative signed the electronic copy, she would forward that to the resident's PCP for final review and obtain their signature. She stated that some of the PCPs they work with will sign the code status form right away, while other PCPs preferred to have a conversation with the resident in person to verify their decision before signing the form. She confirmed that she was responsible for forwarding the resident's code status form to the resident's PCP. She said that "the system is not perfect" when speaking about the process of involving the resident's PCP. She confirmed that she did not involve resident 4, 9, 19, 44, and 59's PCP in the development of the resident's advanced directives. She forwarded those resident's code status forms to their respective PCPs on 12/17/25 during the survey. She confirmed that resident 4, 9, 44, and 59's PCP had signed the code status forms and sent them back on 12/17/25. She was still waiting on resident 19's PCP to review, sign, and send back his code status form. 9. Interview on 12/18/25 at 9:01 a.m. with licensed practical nurse (LPN) V and LPN J revealed that if a resident were found unresponsive, they would check the resident's code status at the top of the dashboard in the EMR before responding to the resident. When asked specifically about resident 44, LPN V went to his profile in the EMR and indicated that the resident's code status was DNR. When she clicked on the "Advanced Directives" link that was next to the DNR code status, it brought her to the "Miscellaneous" scanned documents portion. She pointed out that the most recent code status form (from 4/25/23) available to her indicated that resident 44 was a Full Code. She would have gone by that form. She confirmed she did not have access to the "Document Manager" section of the EMR. 10. Interview on 12/18/25 at 9:06 a.m. with LPN J revealed that she remembered when resident 44's code status was changed. She mentioned that SSD F was responsible for uploading the current code status form	F0578		

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F0578 SS = E	Continued from page 7 into the Document Manager section of the resident's EMR. She mentioned the Document Manager section was not available to the floor nurses, so they may not have the most updated information to respond if a resident had an event that required knowledge of their advanced directives. LPN J opened the resident care plan binder and pointed out that SSD F changed the paper copy of resident 44's care plan. She confirmed that the resident's electronic care plan had not been updated yet and still indicated that resident 44 was a full code. When asked which care plan version she would refer to, she indicated the electronic care plan. 11. Interview on 12/18/25 at 9:19 a.m. with neighborhood leader (NL) W revealed that she was not aware the Document Manager portion of a resident's EMR was not available to the other staff members, like the floor nurses, certified nursing assistants, and certified medication aides. 12. Interview on 12/18/25 at 12:25 p.m. with assistant DON (ADON) C revealed that they included a resident's code status on the resident's care plan. Each department had its respective section on the resident's care plan. The advanced directive section of the resident's care plan was maintained by SSD F. 13. Interview on 12/18/25 at 12:28 p.m. with SSD F revealed that she was involved in developing the resident's care plan. She formulated the following sections: discharge planning, advanced directives, cognition, mood, and psychosocial well-being, and behaviors. The behaviors section was a collaborative effort with the nursing department. She confirmed that "pretty much everyone" will have an advanced directive section. She confirmed that she included the resident's code status on their care plan. She was not aware that resident 59's electronic care plan did not include her code status. She was aware that resident 44's electronic care plan was not updated after his code status changed to DNR on 10/20/25. She explained that she hand-wrote the resident's code status change in the paper copy of the resident's care plan in the care plan binder on the unit. She usually updated the resident's electronic care plan each quarter with their Minimum Data Set (MDS) assessment. Resident 44's code status was changed after his 10/16/25 quarterly MDS assessment, so she had not updated the electronic care plan yet.	F0578		

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F0578 SS = E	Continued from page 8 14. Review of the provider's 10/2025 Advance Directives policy revealed the policy statement read, "Advance directives will be respected in accordance with state law and facility policy." "...7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." "...10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive." "...20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives to that appropriate orders can be documented in the resident's medical record and plan of care." 15. Review of the provider's 4/2025 Do Not Resuscitate Order policy revealed that the policy interpretation and implementation section included: "1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record. a. While awaiting the physician's order to withhold CPR, facility staff should immediately document discussion with the resident or resident representative, including, as appropriate, a resident's wish to refuse CPR. At a minimum, a verbal declination of CPR by a resident, or if applicable a resident's representative, should be witnessed by 2 staff members and documented in the resident's medical record." "2. A Do Not Resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and placed in the resident's medical record."	F0578		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F0584	On 01/13/2026, the Environmental Services Director assessed the rooms of residents 10,17, and all residents to assess damage that may be present in the resident's room. The rooms of residents 10 and 17 will be repaired by 02/01/2026. On 01/12/2026, the IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to the facility work order process, maintenance services, and ensuring a safe and homelike environment. RN G, CNA/CMA M, Maintenance Supervisor E, Housekeeping O, DON B, and all staff will be educated via	02/01/2026

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F0584 SS = D	Continued from page 9 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain resident rooms in a clean and well-kept manner, free from damage to walls, for two of two sampled residents (10 and 17) in one of four facility neighborhoods (Cottonwood Court). Findings include: 1. Observation on 12/16/25 at 10:16 a.m. in resident 10's room and interview on 12/17/25 at 11:50 a.m. with resident 10 in a resident common area between the	F0584	in-service by 02/01/2026 regarding the policies and procedures related to the facility work order process, maintenance services, and ensuring a safe and homelike environment. Beginning 01/19/2026, the Environmental Services Director, or designee, will audit work order completion 3x per week x 4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. Beginning 01/19/2026, the Environmental Services Director, or designee, will audit random resident rooms to ensure they are free from damages or repair needs that would impact the resident's right to a homelike environment 3x per week x4 weeks, 2x per week x4 weeks and 1x per week x4 weeks. The Environmental Services Director, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

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F0584 SS = D	Continued from page 10 neighborhoods revealed: *There were at least three gouges with chipped paint, which were approximately quarter-size, and a gouge with exposed drywall about half-dollar size, in the left wall, between two to three feet above the floor, just inside the resident's door. Additionally, there were vertical scratch marks with chipped paint along the entire length of the left wall. *There were at least three gouges with chipped paint that ranged from one to four inches in size, and vertical scratch marks with chipped paint on the wall to the right, just outside of his bathroom. Additionally, there were vertical scratch marks with chipped paint on the bathroom door frame. *There was a vertical gouge in the wall behind his oxygen concentrator (a machine that takes room air and delivers pure oxygen through a nasal cannula or mask) that was approximately six inches in size. *Along the baseboard beneath his window, there was a vertical gouge about five inches long with exposed drywall and chipped paint. Additionally, there were at least 12 gouges, ranging from the size of a pencil eraser to a dime, along with vertical scratch marks and chipped paint that extended for most of the wall's length. *The resident stated that he accidentally caused the big gauges in the walls when he caught his electric wheelchair on the bed, which caused the bed to hit the wall. *The resident stated that the minor gouges and scratch marks were caused by him moving his electric wheelchair too close to the walls. 2. Observation and interview on 12/16/25 at 10:26 a.m. in resident 17's room revealed: *There were at least six gouges with chipped paint, each about the size of a pencil eraser, and a vertical gouge with chipped paint, approximately two inches long, in the left wall, about two feet above the floor, just inside the resident's door. Additionally, there were vertical scratch marks with chipped paint along the entire length of the left wall. *Along the baseboard of that same wall, there were at least three additional gouges with chipped paint that ranged from dime to quarter size, and vertical scratch	F0584		

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F0584 SS = D	Continued from page 11 marks with chipped paint. *There were at least nine gouges with chipped paint that ranged from a pencil eraser to quarter-size in the right wall, about two feet above the floor, just inside the resident's door. *There were four vertical gouges with exposed drywall on the wall between the resident's bed and his three-drawer wood dresser, approximately three to six inches in size. *There was a hole with exposed drywall and chipped paint in the wall behind the resident's bed, approximately the size of a football. *The resident stated that he caused the damage to the walls by accidentally running his electric wheelchair into them, or when he had maneuvered it too close to the walls. 3. Interview on 12/18/2025 at 10:20 a.m. with registered nurse (RN) G revealed: *Staff were to complete a maintenance request form when they needed something repaired in the facility. *The forms were located on the wall outside the maintenance room door. *She stated that the maintenance office was located in the Willow Wood neighborhood. *She stated that maintenance staff had applied bumpers to residents' beds and placed sandbags behind resident recliner chairs to help prevent damage to the walls. *She stated maintenance staff responded pretty quickly to the request forms completed by staff. 4. Interview on 12/18/2025 at 10:32 a.m. with certified nursing assistant/certified medication aide (CNA/CMA) M revealed: *Staff were to complete a maintenance request form and turn it into the maintenance box when something needed to be repaired in the facility. *She said that staff could call the maintenance staff with an issue, but they would also be asked to fill out a repair form for it.	F0584		

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F0584 SS = D	Continued from page 12 *She stated that the maintenance staff responded quickly to things that needed to be repaired. 5. Interview on 12/18/2025 at 10:57 a.m. with maintenance supervisor E and housekeeping O revealed: *The request/repair requisition forms for maintenance-related work requests were stored in a box attached to the wall in the hall, next to the maintenance office door, labeled "work order forms". *Staff members were to complete a form if something required a repair and put the completed form in the box with the slot labeled "repair requests." *Request forms for repairs were addressed promptly by maintenance staff to ensure the most critical issues were addressed first to maintain resident safety. *Housekeeping O stated that it was hard to repair damaged walls in resident rooms when residents were in their rooms. *Maintenance supervisor E stated that discussions with management had been held to apply bumper pads on walls to help prevent damage in the residents' rooms. *They both clarified that they were aware of the damaged walls in residents 10 and 17's rooms. *They both agreed that it was the maintenance and housekeeping staff's responsibility to keep those areas maintained, organized, and clean. 6. Interview on 12/18/2025 at 11:18 a.m. with director of nursing (DON) B revealed: *She stated it was the maintenance and housekeeping's responsibility to maintain and keep resident rooms and all facility areas organized and clean. *She expected that all resident rooms and utility rooms in the neighborhoods should be organized, well-maintained, and cleaned by the maintenance and housekeeping departments. Review of the provider's January 2025 Maintenance Service policy revealed: *"Policy Interpretation and Implementation."	F0584		

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F0584 SS = D	Continued from page 13 -"1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times." -"2. Functions of maintenance personnel include, but are not limited to:" -".b. maintaining the building in good repair and free from hazards." -".....i. providing routinely scheduled maintenance service to all areas." -"..5. Maintenance personnel shall follow established infection control precautions in the performance of their daily work assignments. -"6. The maintenance director is responsible for maintaining the following records/reports:" -".b. Work order requests." -"7. Records shall be maintained in the maintenance director's office." -"8. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned."	F0584		
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH)	F0600	"Past Noncompliance - no plan of correction required"	

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F0600 SS = E	Continued from page 14 facility-reported incident (FRI), interview, record review, and policy review, the provider failed to protect three of three sampled residents (16, 37, and 50) and one of one closed sampled resident (101) from alleged verbal abuse and neglect. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 9/12/25 submitted to SD DOH FRI final report revealed: *On 9/11/25 at 9:28 a.m., director of nursing (DON) B received a text message from certified nurse aide/certified medication aide (CNA/CMA) Y about CNA/CMA N's interactions with residents in the Maple Valley neighborhood (residential living unit). That neighborhood was a memory care unit (an area where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, which is secured to minimize unsafe wandering). In her text message, CNA/CMA Y indicated CNA/CMA N was: -Withholding fluids from residents during meals because the residents had made "a mess" [drinking their fluids] or "they won't eat they'll be full of their drinks." -Denying resident 50's request for coffee. "[Resident 50] had been asking for hours for coffee and [CNA/CMA N] kept yelling and saying NO." -Not allowing resident 35 to leave the dining room table during a meal after "she [resident 35] had mentioned being full. She [CNA/CMA N] was making her [resident 35] more agitated by forcing big bites in her mouth and yelling 'EAT!'." In a similar instance, CNA/CMA Y had informed CNA/CMA N that resident 101 had finished eating when "she [CNA/CMA N] tried to shove a huge bite [of food] in his mouth because 'he's [the resident] not eating enough' and he spit it [the food] at her." -Yelling at residents "quite often and I [CNA/CMA Y] feel like it creates anxiety and they [the residents] have more behaviors." -Scolding resident 16, who "loves to change her outfits," for wanting to change her clothes too often. CNA/CMA N stated, "You're [CNA/CMA Y] creating work for us and laundry."	F0600		

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F0600 SS = E	Continued from page 15 2. Interviews on 12/17/25 at 10:10 a.m. and 1:45 p.m. with DON B and review of CNA/CMA N's personnel record revealed: *CNA/CMA N's date of hire was 10/15/24. She had a complete and timely background check that was reviewed. Her CNA and CMA certifications were up to date. She had completed resident rights, dementia, and abuse/neglect education in October 2025. There were two disciplinary actions (11/15/24 and 12/24/24) in her file regarding medication administration errors. DON B stated she was not aware of any concerns related to CNA/CMA N's care or treatment of residents before the 9/11/25 text she received from CNA/CMA Y. *CNA/CMA N was suspended from work on 9/11/25 at 11:00 a.m. pending an investigation of CNA/CMA Y's allegations. CNA/CMA N "self-terminated" after that suspension and was not interviewed regarding the allegations due to her no longer working at the facility. *Additional staff interviews completed by DON B after 9/11/25 regarding CNA/CMA N's care and treatment of residents in the Maple Valley neighborhood supported the allegations made by CNA/CMA Y. DON B confirmed the FRI was substantiated for CNA/CMA N's behaviors towards the residents. *Staff education was initiated on 9/11/25 and included a review of the provider's Abuse/Neglect policy. Staff signed and dated an individual acknowledgement of their understanding of the education that was provided for them. Beneath their signature was the following statement: "This form may be used for all types of counseling, including warning records and disciplinary action records." *Two audits were initiated related to the above event. An Abuse/Neglect audit focused on the respectful treatment of residents, resident privacy, the provision of care to meet residents' needs, and staff interactions with residents during care provision. A Staff Reporting audit focused on staff observations of other caregivers, including their interactions with and treatment of residents; if an observation was considered abusive or neglectful, was it appropriately reported, and finally, the audit included whether or not the staff understood the reporting requirements in the facility's Abuse/Neglect policy. 3. Interview on 12/17/25 at 10:20 a.m. with CNA/CMA AA and telephone interview on 12/17/25 at 10:40 a.m. with	F0600		

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F0600 SS = E	Continued from page 16 CNA/CMA Z confirmed they were provided education in September 2025 regarding resident abuse and neglect and the expectations for reporting resident abuse and neglect. They described the audits that occurred after the education was provided, which reinforced the importance and understanding of that education. 4. Observation on 12/16/25 at 9:30 a.m. of CNA/CMA AA with resident 7 in the Maple Valley neighborhood revealed CNA/CMA AA assisted the resident into her room to complete the resident's morning grooming and personal care. There were no concerns regarding CNA/CMA AA's care or treatment of the resident. 5. Observation on 12/16/25 at 10:00 a.m. of CNA/CMAs AA and BB with resident 37 in the Maple Valley neighborhood revealed that the CNA/CMAs assisted the resident into his room. They used a mechanical lift to transfer resident 37 from his wheelchair into the bathroom. After assisting the resident with his personal care, they used the mechanical lift to transfer the resident out of the bathroom and back to his wheelchair. There were no concerns regarding either CNA/CMA AA's or CNA/CMA BB's care and treatment of the resident. 6. Interview on 12/16/25 at 10:15 a.m. with resident 7's spouse in the Maple Valley lounge area revealed his wife resided at the facility for about four years. He visited resident 7 each day from mid-morning until mid-afternoon. He ate lunch with his wife and participated in afternoon activities with her. He voiced no concerns related to the care and treatment staff provided his wife and the other residents in that neighborhood. 7. Observations on 12/16/25 and 12/17/25 of the Maple Valley dining room during the noon meal service revealed no concerns regarding the staff's care and treatment of the residents. 8. Interview on 12/17/25 at 2:00 p.m. with administrator A revealed that he had not observed any concerns nor received any staff concerns about CNA/CMA N's care or treatment of residents before 9/11/25. 9. Interview and record review on 12/17/25 at 1:45 p.m. with DON B revealed the interviews, education, and audits referenced in the provider's 9/12/25 submitted SD DOH FRI were completed and documented. The provider's implemented actions to ensure the deficient practice does not recur were confirmed onsite on 12/17/25 after record review revealed the facility had followed their quality assurance process, education was	F0600		

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F0600 SS = E	Continued from page 17 provided to all direct care staff resident abuse and neglect, FRI-related audits were performed, and observations and interviews confirmed staff understood what constituted resident abuse and neglect as well as the expectations for reporting resident abuse and neglect. 10. Based on the above information, non-compliance at F600 occurred on 9/11/25, and based on the provider's implemented corrective actions initiated on 9/11/25, for the deficient practice confirmed on 12/17/25, the non-compliance is considered past non-compliance.	F0600		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that one of two medication carts was secured while administering medications. Findings Include: 1. Observation on 12/17/25 at 11:35 a.m. of licensed practical nurse (LPN) K revealed: *LPN K had walked away from the Willow Wood Way medication cart to talk to a resident in the dining area and had left the medication cart unsecured and unattended. *LPN K was not standing at the medication cart and returned to lock the cart at 11:41 a.m. *Several residents were seated in the dining area. 2. Interview on 12/18/25 at 11:00 a.m. with LPN K revealed: *She recalled walking away from the medication cart and not locking it on 12/17/25. *She reported she made a mistake, and she usually locked it when she walked away from it. The medication	F0658	On 01/12/2026 the IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to medication security. LPN K, RN NL I, and all staff will be educated via in-service by 02/01/2026 regarding the policies and procedures related to medication security. Beginning 01/19/2026 the DON, or designee, will audit that medication carts are locked appropriately 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. DON, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	02/01/2026

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F0658 SS = D	Continued from page 18 cart should have been locked each time she walked away from it to ensure it was secured from unauthorized access. 3. Interview on 12/18/25 at 12:00 p.m. with registered nurse (RN) neighborhood leader I revealed: *She witnessed LPN K when she walked away from the medication cart on 12/17/25. *She expected the medication cart to be locked anytime the employee administering medications walked away from it. *She confirmed that medications should be secured at all times. 4. Review of the provider's 1/2025 Security of a Medication Cart policy revealed: *"The nurse/medication aide must secure the medication cart during the medication pass to prevent unauthorized entry." *"Medication carts must be securely locked at all times when out of the nurse's/medication aide's view."	F0658		
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 observation, interview, and policy review, the provider failed to ensure a coffee maker/hot water dispenser in the Maple Valley neighborhood dining area was securely stored to protect the safety of vulnerable residents. Findings include:	F0689	On 12/17/2025, the Environmental Services Director repaired the lock on the coffee station on Maple Valley to ensure it was inaccessible when not in use by staff. On 01/13/2026, the Environmental Services Director ensured that the coffee stations on all other neighborhoods also had the same security as Maple Valley's to prevent potential accidents. On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to hot liquid safety and safety and supervision of residents. CNA X, Administrator A, Maintenance Supervisor E, and all staff, will be educated via in-service by 02/01/2026 regarding the policies and procedures relating to hot liquid safety and safety and supervision of residents. Beginning 01/19/2026 the Environmental Services Director, or designee, will audit that all coffee stations on the resident neighborhoods have proper security features and that the features are in working order 3x per week x4 weeks, 2x per week x4 weeks, 1x per week x4 weeks. The Environmental Services Director, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	02/01/2026

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F0689 SS = D	Continued from page 19 1. Observation on 12/16/25 at 9:45 a.m. in the Maple Valley neighborhood (residential living area) revealed it was a memory care unit (an area where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, that is secured to minimize unsafe wandering). The unit's dining area was large and opened into a living room and a lounge area for the residents. Residents used the dining area not only for meals and snacks but also for structured social activities. Some of the six to eight residents who were present in the dining area during the observation walked independently or with the use of an assistive device, such as a walker. Other residents relied on the staff for their mobility. There was a countertop that extended the length of a wall on one side of the dining area. There was a set of tall cabinet doors on top of the countertop. The cabinet doors were positioned close enough to the edge of the countertop to be easily opened. There was an approximate one-inch gap when the two cabinet doors were closed. There was a broken, plastic safety device near the top of the cabinet doors to prevent the doors from opening. There was a cam lock (an L-shaped locking mechanism used to secure a cabinet door) towards the bottom of the right cabinet door. It was not engaged. Nothing prevented the cabinet doors from being opened. Behind the unsecured cabinet doors was a coffee maker that was equipped with a coffee warmer and a hot water dispenser. It was turned on and able to dispense hot liquids. 2. Observation on 12/17/25 at 3:45 p.m. in the Maple Valley dining area revealed that the above cabinet doors were closed and nothing prevented them from being opened. The temperature of the water dispensed from the hot water dispenser was tested by the surveyor, and it was 170 degrees. That was hot enough to have caused a third-degree burn if it had touched a resident's skin. 3. An interview conducted at the same time with	F0689		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 20 certified nurse aide (CNA) X revealed that residents who had wandered towards the unsecured cabinet doors were redirected by staff before they were able to open the doors. CNA X was unsure how long the plastic security device on the cabinet door had been broken or if the maintenance department was aware that it needed to be fixed. She had not known where or if there was a key to secure the cam lock on the cabinet doors. She was not aware of any resident burn injuries related to a resident accessing hot beverages from behind those cabinet doors. She confirmed that the hot liquid temperature posed a burn risk if a resident accessed that machine. 4. Interview on 12/17/25 at 4:00 p.m. with administrator A and maintenance supervisor E regarding the above cabinets in the Maple Valley dining area revealed that they were not aware that the safety devices on the cabinet doors were either broken or unable to be used. It was expected that the staff would have promptly notified the maintenance department of this failure, so a temporary measure could have been implemented to ensure the residents' safety from a potential burn from the coffee maker/hot water dispenser until a permanent solution was in place. Review of the provider's January 2025 Hot Liquids Burn Prevention policy revealed "2. The cabinet containing hot liquids on Maple Valley is to remain inaccessible by use of childproof locks. Staff on Maple Valley also provide oversight to ensure that residents are not accessing hot liquids when they are unable to do so safely."	F0689		
F0695 SS = E	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 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 follow their	F0695	On 01/12/2026 the IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to resident respiratory care. On 01/13/2026, the DON, or desginee, assessed the respiratory care devices of residents 8, 10, 49, and all residents to ensure their equipment was being stored appropriately. Resident 4 discharged from the facility on 01/09/2026. On 01/13/2026, the DON, or desginee, reviewed the respiratory care orders of residents 8, 10, 49, and all residents to ensure orders regarding respiratory care are accurate. Resident 4 discharged from the facility on 01/09/2026. Reviews will be completed by 01/16/2026. RN G, NL H, NL I, DON B and all staff will be educated via in-service by 02/01/2026 regarding the policies and procedures related to resident respiratory care. Beginning 01/19/2026, DON, or designee, will audit respiratory care equipment to ensure that it is being stored	02/01/2026

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F0695 SS = E	Continued from page 21 policy and provide the necessary respiratory care and services for four of four sampled residents (4, 8, 10, and 49), resulting in inadequate storage, humidification, and replacement of those devices. Findings include: 1. Observation and interview on 12/16/25 at 10:45 a.m. with resident 49 in her room revealed: *She was sitting in her recliner chair. *She had an oxygen concentrator machine (a machine that filters room air into pure oxygen and then delivers it through a tube with prongs that fit in the nostrils or a mask) next to the foot of her bed. *She had oxygen nasal cannula tubing (tubing that delivers oxygen through the nose) stored on top of the concentrator. -The tubing was not dated, and there was no storage bag or other container to hold the tubing when it was not in use. *A nebulizer machine (a medical device that turns liquid medicine into a mist that is then inhaled into the lungs through a mask or mouthpiece) was sitting on the floor between her two recliner chairs. *The nebulizer tubing and mask were attached to the nebulizer machine and were not dated. *The nebulizer tubing and mask were then draped over the right arm of the light green recliner. *The nebulizer mask rested on a pink plush blanket that was in the chair. -The nebulizer machine and mask were not stored on a clean barrier to protect them from potential contamination. Review of resident 49's electronic medical record (EMR) revealed: *She was admitted on 5/21/24. *She was diagnosed with chronic obstructive pulmonary disease (COPD). *She had an order for oxygen via nasal cannula as needed to keep oxygen saturation greater than 90	F0695	and cleaned according to policy 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. Beginning 01/19/2026, DON, or designee, will audit resident respiratory care orders to ensure that all orders contain the required documentation 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. DON, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	

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F0695 SS = E	Continued from page 22 percent. -That order started on 6/26/24. *There was no documentation on her electronic medication/treatment administration record (EMAR/ETAR) for December 2025, indicating she used oxygen. *There were no physician or nursing orders to change the humidification bottle on the oxygen concentrator or the oxygen tubing on a scheduled basis. *There were no physician or nursing orders to change the nebulizer tubing or replace the mask on a scheduled basis. 2. Observation and interview on 12/16/25 at 11:18 a.m. with resident 4 in his room revealed he had an oxygen concentrator machine next to his bed. There were no markings on the oxygen tubing or the humidifier bottle to indicate when those were last changed. He said that he used the oxygen machine when he first admitted to the facility on 11/18/25 but had not used it "in a long time." Review of resident 4's electronic medical record (EMR) revealed he had a physician's order for "Oxygen via [nasal cannula] as needed to keep oxygen saturation [greater than 90 percent]." That order was started on 11/18/25. There were no physician's or nursing orders to change the humidifier bottle or oxygen tubing on a scheduled basis. The last time it was documented that the resident used the oxygen concentrator machine was on 11/19/25, when his blood oxygen concentration was measured at 95 percent "Oxygen via Nasal Cannula." 3. Observation on 12/16/25 at 2:05 p.m. of resident 8 in her room revealed *She was lying in her bed and wearing oxygen via a nasal cannula. *She had an oxygen concentrator machine next to her bed that was running and set at 4 liters. *There was a humidification bottle connected to the concentrator. -The connection tube, humidification bottle, and nasal cannula tubing were not dated.	F0695		

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F0695 SS = E	Continued from page 23 *She had a nebulizer machine on top of the wooden dresser, and the nebulizer tubing was wrapped around the machine. *The nebulizer tubing was not dated. Review of resident 8's EMR revealed: *She was admitted on 12/21/20. *She was diagnosed with hypoxia (low oxygen levels in the blood). *She had an order for oxygen via nasal cannula as needed to keep oxygen saturation greater than 90 percent. -That order started on 12/21/20. *She had an order that oxygen may be titrated from 1 liter up to 5 liters to maintain oxygen saturation greater than 90 percent or above every shift. -That order started on 12/1/25. *It was documented that she wore the oxygen every shift. *There were no physician or nursing orders to change the humidification bottle or the tubing on a scheduled basis. *There were no physician or nursing orders to change the nebulizer tubing or replace the mask on a scheduled basis. 4. Observation on 12/16/25 at 3:19 p.m. in resident 10's room revealed: *He had an oxygen concentrator machine next to his bed. *There was a humidification bottle connected to the concentrator. -The connection tubing that connected the humidification bottle to the concentrator was dated 10/26. -The humidification bottle was not dated. *He had a continuous positive airway pressure (CPAP) machine (a machine to treat sleep-related breathing	F0695		

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F0695 SS = E	Continued from page 24 issues) on top of the dresser next to the bed. -The oxygen tubing on the concentrator that connected to the CPAP was dated 10/26. *The oxygen tubing was on the floor, and there was no storage bag or other container to hold the tubing when it was not in use to protect it from potential contamination. Review of resident 10's EMR revealed: *He was admitted on 4/12/24. *He was diagnosed with obstructive sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep) and acute respiratory failure with hypoxia (low oxygen levels in the blood). *He had an order to wear the CPAP per home settings at night. -That order started on 4/24/24. *It was documented that he wore the CPAP every night. *He had an order for oxygen via nasal cannula as needed to keep oxygen saturation greater than 90 percent. -That order started 9/17/25. *There were no physician or nursing orders to change the humidification bottle or the oxygen tubing for his concentrator and CPAP on a scheduled basis. 5. Interview on 12/17/25 at 9:50 a.m. with registered nurse (RN) G regarding respiratory equipment in resident 10's room revealed: *She was unsure if the oxygen tubing residents used was changed every two weeks or once a month. *She stated that the oxygen tubing should be dated and stored in a bag when it was not in use. *Oxygen tubing was to be replaced by the night shift when the task was generated on the resident's EMAR/ETAR. *She stated that staff received annual oxygen training that was offered in the spring and fall.	F0695		

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F0695 SS = E	Continued from page 25 *She confirmed that resident 10's oxygen and connection tubing were dated 10/26. *She agreed that it had not been changed in over a month and removed the tubing. 6. Interview on 12/17/25 at 10:08 a.m. with RN/neighborhood leader H revealed: *She stated oxygen tubing for residents was to be changed every two weeks, dated, and possibly initialed by the staff who changed the tubing. *Oxygen tubing was to be in a storage bag when it was not in use to protect it from potential contamination. *She stated that the humidification bottles on the oxygen concentrators were to be changed on the same schedule as the oxygen tubing. 7. Interview on 12/17/25 at 10:42 a.m. with RN/neighborhood leader I revealed: *She was unsure when oxygen and nebulizer tubing for residents were to be changed. 8. Interview on 12/17/25 at 10:51 a.m. with director of nursing (DON) B revealed: *She stated that the residents' oxygen tubing was to be replaced twice monthly, and the nebulizer tubing and the mask/pipe were to be replaced every seven days according to their policy. -All oxygen and nebulizer tubing and supplies were to be dated and initialed by the staff when they were changed. *The night shift nursing staff were primarily responsible for the task of replacing the oxygen and nebulizer tubing as scheduled, but on occasion, this task could be assigned to the day shift nursing staff to complete. *There was to be a storage bag for the oxygen tubing to be stored in when it was not in use, and it was to be dated and initialed by the staff who changed it. *She stated staff were expected to place a clean barrier for the storage of the nebulizer mask/pipe to be stored on when not in use.	F0695		

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F0695 SS = E	Continued from page 26 *It was her expectation that nebulizer machines should not be stored on floors because dirty floors were a potential source of infection. *It was her expectation that oxygen tubing should be replaced twice a month and nebulizer tubing should be replaced once a week. -The supplies should be dated, initialed by staff who changed them, and appropriately stored. Review of the providers reviewed 10/25 Oxygen Administration policy revealed: *"Preparation:" -"1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." *"Steps in the Procedure:" *"Cleaning Schedule:" -"1. Oxygen tubing and humidifier: changed the 1st and the 15th of the month and as needed along with the storage bag." -"2. Oxygen tubing, humidifier, and storage bag should be dated and initialed when changed." Review of the providers reviewed 12/25 Administering Medications through a Small Volume (Handheld) Nebulizer policy revealed: *"Preparation:" -"1. Obtain a physician's order as needed." -"...17. Rinse the nebulizer equipment according to facility protocol, or:" --"a. wash pieces with warm, soapy water;" --"b. rinse with hot water;" --"c. allow to air dry on a paper towel or in nebulizer drying bags." -"...19. Change equipment, tubing, and drying bag every seven days. Equipment should be dated and initialed	F0695		

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F0695 SS = E	Continued from page 27 when changed." -"20. Disinfect outside of the Nebulizer Machine between residents, according to manufacturer's instructions."	F0695		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to: *Maintain food safety requirements related to one of one Maple Valley neighborhood pantry room, and one of one Maple Valley kitchenette. *Maintain clean and sanitary conditions for three of three foodservice handwashing sinks in the Plum Creek neighborhood. *Implement interventions to supervise and monitor resident refrigerator temperatures to identify any hazards of foodborne illness for two of two observed residents (17 and 24).	F0812	On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to safe dish/food storage, personal resident refrigerators and neighborhood cleaning schedules. On 01/13/2026, the Environmental Services Director, or designee, assessed the refrigerators for residents 17 and 24 to ensure their cleanliness and to ensure that there were thermometers in place to record the refrigerator's temperature. On 01/13/2026, the Environmental Services Director, or designee, reviewed all resident rooms to ensure that there were no other personal resident refrigerators unaccounted for. On 01/13/2026, DON, or designee, assess the dish storage in each kitchenette on each neigbhorhood to ensure all clean dishware was stored appropriately. Deep cleanings of the dish areas will be completed by 01/16/2026. On 01/13/2026, housekeeping staff will deep clean all food service handwashing sinks. On 01/13/2026, the Dietary Director, or designee, will ensure that all dish carts are properly cleaned. Beginning 01/13/2026, housekeeping staff will clean all cabinets on the neighborhoods. Cleanings will be completed by 01/16/2026. CNA/CMA AA, DON B, Dietary Manager D, RN G, RN H, Maintenance Supervisor E, Housekeeping P, CNA L, LPN J, Housekeeper Q, Administrator A, and all staff will be educated via in-service by 02/01/2026 regarding the policies and procedures relating to safe dish storage and personal resident refrigerators. Beginning 01/19/2026, the Environmental Services Director, or designee, will audit that personal resident refrigerators are clean and that their temperatures are recorded 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. Beginning 01/19/2026, DON, or designee, will audit that kitchenettes are clean and that dishes are being stored appropriately 3x per week x 4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. Beginning 01/19/2026, the Environmental Services Director, or designee, will audit that all food service hand washing sinks are clean and free of debris 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. Beginning 01/19/2026, the Environmental Services Director, or designee, will randomly audit neighborhood cabinets to ensure they are clean and free of debris 1x per week for 90 days.	02/01/2026

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F0812 SS = E	Continued from page 28 Findings include: 1. Observation on 12/16/25 at 9:47 a.m. of the Maple Valley neighborhood food service pantry revealed: *A wheeled cart was inside that room. Clean drinking cups, coffee mugs, silverware wrapped in napkins, a water pitcher, and a plate guard sat on a towel on top of that cart. One end of the cart had openings for pushing the cart. There were multiple, dried white-colored runs down the inside lip of that end of the cart near the edge of the towel and by the clean kitchenware. The clean kitchenware was not stored in a way that would mitigate contamination. *There were two wire shelving units inside that pantry room. A "Clean" sign hung on the front of and below the top shelf of the first unit. A sign next to the first sign read "All dishes placed on this rack must be faced down and on a tray." It was unclear if those signs applied to the items on the top shelf, the second shelf, or both shelves. The following items were not stored in a manner to protect them from becoming contaminated: -A rolling pin and muffin tin sat directly on the top shelf. There was an opened plastic bag of Styrofoam food storage boxes, also on the shelf. -A lidded plastic cup with a flexible straw, stacked bowls, a plastic water pitcher, a plastic measuring cup, insulated lids, plastic cups, and other miscellaneous kitchen items sat directly on the second shelf. *On top of a dorm-sized freezer next to the above shelving unit were measuring cups, bowls, a water pitcher, a food thickening dispenser, and a plastic-covered pan of dessert. *The second wire shelving unit was directly across from the first. Hanging from the second shelf of that unit was a "Dirty" sign. Sitting directly on that same shelf, there were stacks of folded clean dish rags. -To the right of the rags was a Styrofoam cup lid lying directly on the shelf, and an open sleeve of the same type of lids. Behind that, a small stack of Styrofoam food containers and plates lay directly on the shelf. -To the left of the dish rags was an open sleeve of Styrofoam cups. In front of that bag were several plastic forks lying directly on the shelf. A spray bottle containing sanitizer hung off the shelf next to	F0812	Beginning 01/19/2026, the Dietary Director, or designee, will audit dish carts to ensure they are clean and free of debris 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. The Environmental Services Director, DON, and the Dietary Director, or their designees, will present the findings of the audits to the QAPI committee at their quarterly meeting for review and recommendations.	

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F0812 SS = E	Continued from page 29 that. Behind that was an opened box with plastic spoons and Styrofoam cups inside it. *On the bottom shelf, a baking sheet lay directly on top of that shelf. A plastic fork sat on top of the sheet. There were Styrofoam plates and plastic lids next to a bottle of Goof-Off (latex paint and adhesive remover) and a gallon-size jug of dish soap next to it. Behind those cleaning supplies were multiple used flower vases. 2. Continued observation of the Maple Valley neighborhood kitchenette area revealed: *Inside the cabinet next to the steam table, Styrofoam bowls, plates, canned soup, and snacks were stored. The inside of those cabinet doors appeared to be coffee-stained. Two of the shelves inside that same cabinet appeared to be coffee-stained. *Inside the top drawer beside the stove were two soiled oven mitts and a pair of scissors stored with a spatula and a set of tongs. 3. Observation and interview on 12/16/25 at 10:26 a.m. with resident 17 in his room of the Cottonwood Court neighborhood revealed: *He had a personal refrigerator in his room. *He mentioned that his children were responsible for cleaning and disposing of expired food items. *He said staff would check the temperature of his refrigerator approximately once a week. *The refrigerator was mildly dirty, with small food particles observed on the shelves and inside the door. *The freezer section had a moderate buildup of frost and ice. *There was a small opened jar of strawberry jam, an opened squeeze-bottle of Miracle Whip salad dressing, an opened container of French onion dip, and an opened package of sliced cheese stored in the door of the refrigerator. *There was no temperature log located on or near the refrigerator. *There was no thermometer in the refrigerator to know	F0812		

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F0812 SS = E	Continued from page 30 the current temperature of it. 4. Interview on 12/16 at 3:45 p.m. with certified nurse aide/unlicensed medication aide (CNA/UMA) AA inside the Maple Valley pantry revealed that the cart holding the clean dinnerware remained in that room. She agreed that the cart was unclean, but she had not known who was responsible for cleaning it. She thought the "Dirty" sign on the second shelving unit should have been removed. She had not known who was responsible for organizing and keeping the pantry room clean. Items in the pantry and kitchenette should have stored or covered in a manner to protect them from potential contamination. 5. Interview on 12/16/25 at 4:10 p.m. with director of nursing (DON) B in the Maple Valley pantry and kitchenette revealed that a combined effort between nursing staff and dietary staff was expected to maintain the pantry and the kitchenette cleanly and safely for food service and cookware. There was nothing for those staff to refer to for them to know the expectations for maintaining the pantry and kitchenette cleanly and safely, who was responsible for what tasks to maintain those areas, or how frequently it was expected that those tasks occurred though. She agreed that based on the above observations, the pantry and kitchenette had not been maintained in a manner to keep it organized, clean, and sanitary for food service. 6. Interview on 12/16/25 at 4:00 p.m. with dietary manager (DM) D regarding the Maple Valley pantry and kitchenette revealed that nursing staff were responsible for maintaining those areas. Nursing staff were also responsible for returning the carts with dirty dishes to the kitchen for cleaning. Dietary staff were responsible for returning the cleaned carts to the neighborhood. 7. Observation and interview on 12/16/25 at 4:30 p.m. with resident 24 in his room of the Willow Wood neighborhood revealed: *He had a personal refrigerator in his room. *He said that his children were responsible for cleaning and disposing of expired food items. *He was unsure if the staff checked the temperature of the refrigerator daily.	F0812		

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Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 31 *There was an open package of potato lefse (a soft flatbread made from riced potatoes, flour, butter, and cream or milk) stored on a shelf in the refrigerator. *There was no temperature log located on or near the refrigerator. *There was no thermometer in the refrigerator to know the current temperature of it. 8. Observation on 12/17/25 at 8:06 a.m. in the Plum Creek neighborhood pantry room behind the kitchenette revealed the handwashing sink had unidentified food scraps that appeared to have been tomato skins stuck to the drain catch. 9. Observation on 12/17/25 at 9:55 a.m. in the Plum Creek dining room revealed the handwashing sink next to the beverage dispensers was stained with what appeared to be coffee or brown-colored rust. 10. Interview on 12/17/25 at 10:35 a.m. with registered nurse (RN) G revealed: *She stated resident families were responsible for the residents' personal refrigerators. *The nursing staff was not responsible for the resident refrigerators. 11. Interview on 12/17/25 at 10:43 a.m. with RN/neighborhood leader H revealed: *She stated that residents and resident families were responsible for cleaning, disposing of outdated food items, and checking the temperatures of the refrigerators. *The nursing staff was not responsible for the resident refrigerators. 12. Interview on 12/17/25 at 11:03 a.m. with director of nursing (DON) B revealed: *She stated that residents and families were notified and given the information about personal refrigerators upon admission or as they had requested.	F0812		

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F0812 SS = E	Continued from page 32 *She stated that residents and families were responsible for cleaning and disposing of outdated food items on a routine basis. *She indicated housekeeping was responsible for checking the residents' refrigerator temperatures daily and maintaining the logs of those temperatures. *She confirmed that resident refrigerators should have had a thermometer in them and that it was the responsibility of the facility to have one for each resident refrigerator. *The refrigerator temperatures should have been maintained between 36 and 46 degrees Fahrenheit (F) for food safety. *She agreed that to avoid a hazardous foodborne illness, resident refrigerators should have been checked daily for appropriate temperatures. *It was her expectation that the temperatures for the refrigerators in resident rooms were checked and documented daily by housekeeping. 13. Interview on 12/17/25 at 11:43 a.m. with maintenance supervisor E revealed: *He was asked to provide the residents' refrigerator temperature logs for the past two months. -He stated that the previous maintenance supervisor and housekeeping had not maintained the resident refrigerator temperature logs. *He stated that he was unaware that the refrigerator temperatures in residents' rooms needed to be checked daily. *He stated that the housekeepers did not know and were not told or educated to check the resident refrigerator temperatures daily. *He confirmed that no resident refrigerator temperatures had been completed, and no logs had been maintained for those refrigerators. *He agreed that to avoid a hazardous foodborne illness, temperatures in resident refrigerators should be checked and documented daily to ensure they were in the appropriate temperature range for food safety.	F0812		

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F0812 SS = E	Continued from page 33 14. Interview on 12/17/25 at 1:51 p.m. with housekeeping P revealed: *She stated that she had not checked or documented any resident refrigerator temperatures. *She indicated that she had not been told or educated to perform that housekeeping task. 15. Interview on 12/18/25 at 10:50 a.m. with DM D and DON B revealed that the nursing and housekeeping departments were responsible for cleaning the handwashing sinks on the resident neighborhoods. DM D said that food and beverages were not supposed to be poured down the handwashing sinks in those areas. 16. Interview on 12/18/25 at 10:55 a.m. with CNA L revealed that the CNAs cleaned the tables and counters after each meal. She was not sure who was responsible for cleaning the handwashing sinks in the dining room, in the kitchenette, or in the pantry room. She did not know if there was a cleaning checklist or not. 17. Interview on 12/18/25 at 10:57 a.m. with licensed practical nurse (LPN) J revealed that she thought that there was a cleaning checklist for the CNAs for the kitchenette and dining room areas. She looked through several binders in the kitchenette and nursing station cupboards, but she could not find a cleaning checklist for them. 18. Observation on 12/18/25 at 10:59 a.m. in the Plum Creek kitchenette revealed there were food scraps and coffee grounds in the handwashing sink located to the right of the oven. The unidentified food scraps that appeared to have been tomato skins (from the observation on 12/17/25 at 8:06 a.m.) were still present in the handwashing sink located in the pantry room. 19. Interview on 12/18/25 at 11:02 a.m. with housekeeper Q revealed that she gave conflicting responses when asked if the housekeeping staff were responsible for cleaning the handwashing sinks in the resident neighborhoods. She at first said that she cleaned them every day, but then she said she cleaned them once per week. She said she does not clean the handwashing sink in the pantry room located behind the kitchenette.	F0812		

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F0812 SS = E	Continued from page 34 20. Interview on 12/18/25 at 11:57 a.m. with administrator A revealed he expected staff to refrain from pouring food and beverages down the handwashing sinks. He explained that it was the housekeeping staff's duty to perform regular cleaning of the resident areas like the dining room, kitchenette, the beverage station, and the handwashing sinks. Review of the providers reviewed 8/2025 Resident Refrigerator policy revealed: *"Policy:" -"..C. Nursing will obtain the thermometer from dietary which will be placed in the refrigerator." -"D. Housekeeping checks the temperature of the fridge in resident's room." -"E. Resident/family will ensure that all food placed in the refrigerator is covered. After opening the container, it is to be used or removed within an acceptable time frame." -"F. The refrigerator is to be cleaned by the family member." -"G. Housekeeping staff will check to ensure the resident or family member is removing and disposing of open items and keeping the refrigerator clean." -".I. If the resident or family member is unable to maintain the refrigerator according to the policy/procedure, staff will advise the family that it will have to be removed."	F0812		
F0880 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.	F0880	On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to expired supplies rotation and established a cleaning schedule for the utility rooms. On 01/13/2026, the hand sanitizer bottles outside of residents 9 and 58's room were removed and disposed of. Resident 12 discharged from the facility on 12/30/2025, but the expired hand sanitizer was still removed and disposed of. Beginning 01/13/2026, all expired hand sanitizer and germicidal wipes were removed from active use. All sanitizer and germicidal wipes will be replaced by 01/16/2026. Beginning 01/13/2026, housekeeping staff will deep clean all clean and dirty utility rooms and repair any equipment	02/01/2026

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F0880 SS = E	Continued from page 35 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 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.	F0880	that is in need of repair and remove any items that should not be stored in those rooms. Deep cleanings will be completed by 01/16/2026. Repairs will be completed by 02/01/2026. ADON C, Maintenance Supervisor E, Housekeeping O, DON B, and all staff will be educated via in-serivce by 02/01/2026 regarding the policies and procedures related to expired supplies rotation and the utility room cleaning schedules. Beginning 01/19/2026, the Environmental Services Director, or designee, will audit that expired supplies are not in circulation in resident care areas 3x per week x4 weeks, 2x per week x4 weeks, 1x per week x4 weeks. Beginning 01/19/2026, the Environmental Services Director, or designee, will audit that clean and dirty utility rooms are in good repair and do not have any item being stored in them improperly 1x per week for 90 days. The Environmental Services Director, or designee, will present the findings of the audits to the QAPI committee at their quarterly meeting for review and recommendation.	

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F0880 SS = E	Continued from page 36 §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 staff members followed proper storage and cleaning procedures for both clean and dirty utility rooms in two of the four facility neighborhoods (Plum Creek and Willow Wood) to prevent the spread of infection. *Discard products found in one of four resident neighborhoods, such as hand sanitizer and germicidal (germ-killing) wipes, on or before the expiration date which had the potential to affect all people in the facility. Findings include: 1. Observation on 12/17/25 at 2:03 p.m. in the common area outside the beauty/barber shop revealed an automatic hand sanitizer dispenser on the wall. The hand sanitizer had expired on 6/20/25. 2. Observation on 12/17/25 between 2:16 p.m. and 2:24 p.m. in the soiled utility room of the Plum Creek neighborhood revealed: *A four-product disinfectant dispensing system that was mounted inside the door on the left wall with black and white discharge tubes and hoses connected to dispense the chemicals. *An unconnected, black discharge hose, approximately five feet long, was coiled up and lying in the bottom of the drain tub. *The caulking around the drain tub had a black substance coating it. *There was a stainless steel two-compartment sink with	F0880		

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F0880 SS = E	Continued from page 37 counterspace cluttered with chemicals, glass jars, vases, and a pink basin of items. *One compartment of the sink contained a white bucket with dirty water that had a white film on the top. *The counter space on the left side of the sink contained two opened containers of Micro-Kill disinfectant. -The lids were off and faced down, lying on the countertop next to a dirty micro-fiber rag and a blue writing pen. *The right side of the counter space contained three empty glass jars and one empty glass flower vase. *The right side of the counter space contained a pink basin that held a container of Lime-Away, a spray bottle of Clorox Urine Remover, a plastic bag that contained instructions for the splash guard (a shield to prevent splashing by blocking liquid waste and protecting workers), and a soiled blue and white sponge. *Four floor tiles under the left side counter space of the sink had a dry white film substance on them. *An empty cardboard box was on the floor near the left side of the sink. *There were three empty clothes baskets on the floor under the right side of the counter space. *The soiled hopper sink (a plumbing fixture that safely disposes of liquid or semi-solid biological waste) was missing the splash guard. -The splash guard was lying on the floor between the hopper and the hand-washing sink. *The rinse hose was hanging from the holder and submerged in the dirty water of the hopper sink. *The hopper sink had a strip of black "sticky" material approximately ten inches long that ran along the front edge, where the splash guard had once been attached. *There were no gowns, gloves, or goggles available near the hopper for staff use. *Areas of the floor were visibly soiled with dirt, lint, and dust fibers.	F0880		

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F0880 SS = E	Continued from page 38 3. Observation on 12/17/25 between 2:25 p.m. and 2:34 p.m. in the clean utility room of the Plum Creek neighborhood revealed: *A sign posted on the door read: "CLEAN UTILITY ROOM: ONLY ITEMS THAT ARE CLEAN OR HAVE BEEN CLEANED CAN BE IN HERE". *On the floor just inside the door, along the left wall, was an oxygen concentrator machine that appeared dirty. *It had a humidification bottle that contained approximately 1/3 of water and a connection tube attached. *There was a black wire storage container on the floor that had a gray bin, and a black wall-mount clock stored in it. *There were two large boxes and two small boxes of Halloween decorations stacked on top of two white laundry baskets stored on the floor. *On the floor just inside the door, along the right wall, there was a white three-drawer bin, and the drawers were visibly dirty with lint, material fibers, and dirt. *There were four large white clothes baskets stacked on top of each other and stored on the floor next to the three-drawer bin. *There was a large opened cardboard box on the floor that contained yellow disposable gowns, boxes of N95 respirator masks, and clear plastic mountable file holders. *There was a tall wooden stand with four visibly dusty compartments stored on the floor, and a nebulizer machine that appeared dirty stored on top of it. *On the floor was a large box with Halloween and fall decorations, with a large, clear garbage bag of fall decorations stored on top of it. *The left countertop next to the sink stored two unopened cardboard boxes of hand soap, two unopened boxes, and one opened box of N95 respirator masks, which could have become wet if someone washed their hands at the sink.	F0880		

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F0880 SS = E	Continued from page 39 4. Observation on 12/17/25 between 2:35 p.m. and 2:45 p.m. in the soiled utility room of Willow Wood neighborhood revealed: *A four-product disinfectant dispensing system that was mounted inside the door on the right wall with black and white discharge tubes and hoses connected to dispense the chemicals. *An opened multi-surface disinfectant container was stored on the floor in front of the drain sink. -The disinfectant had one end of a white discharge tube placed into the opening of the black lid, while the other end of the discharge tube was lying on the visibly soiled floor next to the drain sink. *The caulking around the drain tub had a black substance coating it. *A yellow mop bucket that appeared dirty was stored in the drain sink. *A clear discharge hose, stained brown, contained brown and black residue on the inside of the tube and was coiled around the cold-water faucet handle. *The wall behind the drain sink was coated in dirt and a layer of brown film. *A tan wheeled cart cluttered with paint supplies was placed just inside the door, which blocked the entrance and needed to be moved to access the room. *There was a stainless steel two-compartment sink with counter space cluttered with various items and chemicals. *The right side of the counter space contained five opened containers of cleaning chemicals. -The spray nozzle for the opened container of multi-surface peroxide was stored next to it. *There was a large black bucket in one sink compartment that contained used paint rollers and supplies with water that had formed a milky-gray film on top. *A visibly soiled white bath towel was draped over the right edge of the sink. *The left side of the counter space was blocked by a cupboard door approximately four feet tall and a large black and yellow wheeled floor cleaning machine.	F0880		

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F0880 SS = E	Continued from page 40 *The stainless steel two-compartment sink with counterspace contained a white bucket with dirty water in one compartment of the sink that had a white film that formed on top of the water. *The soiled hopper sink was missing the splash guard, and it was lying on the floor up against the wall next to a black trash bag. -The hopper sink had a paint pan with dried paint stored on top of it. *The hopper sink had a strip of black "sticky" material approximately ten inches long that ran along the front edge, where the splash guard had once been attached. *There were no gowns, clean gloves, or goggles available near the hopper for staff use. *There were two fans visibly soiled with dust fibers and a small black and green spot cleaner with an attached hose stored on the floor in front of the handwashing sink. *There were two opened boxes of large and medium disposable gloves stored on the sink behind the handwashing faucet. -The gloves in the medium box were visibly stained and dirty with a dried, dark brown liquid substance. *The dark-brown liquid substance was noted at the bottom of the sink around the drain, and the sink tub was visibly soiled with dirt and brown film. *There was a white lid for a chemical container stored on the inside ledge of the sink, and there were white lids for chemical containers on the floor under the sink. *The floor was visibly soiled with dirt, lint, and dust fibers.*The right countertop next to the sink stored four large cardboard boxes of unopened copy paper, which could have become wet if someone washed their hands at the sink. -On top of a box of copy paper was a brown wicker basket that contained a silk flower arrangement. *The floor was visibly soiled with dirt, lint, and dust fibers.	F0880		

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F0880 SS = E	Continued from page 41 5. Observation on 12/17/25 at 2:36 p.m. in the Plum Creek whirlpool tub room revealed that there was an automatic foaming hand sanitizer dispenser on the wall. The bottle of hand sanitizer product had a manufacturer's expiration date of 6/20/25 according to the label. In a cupboard under the sink, there was a container of "Micro-Kill AF2" disinfecting wipes with a "Best By" date of 5/3/25 according to the manufacturer's label. There was another container of "SANI-CLOTH BLEACH" germicidal wipes with an expiration date of "03/2021." There was a date of "Opened on 07/14/21" handwritten on that container. A second container of the "SANI-CLOTH BLEACH" germicidal wipes had an expiration date of "03/2024." 6. Observations throughout the Plum Creek neighborhood on 12/17/25 from 2:45 p.m. to 2:53 p.m. revealed there were several bottles of green aloe hand sanitizer throughout the Plum Creek unit that were expired. There were three bottles of the aloe hand sanitizers on shelves outside of resident 9, 12, and 58's rooms. The bottles outside of resident 9's and 58's room had expiration dates of "OCT 2025." The bottle outside of resident 12's room had an expiration date of "DEC 2024." 7. Observation on 12/17/25 between 2:46 p.m. and 2:55 p.m. in the clean utility room of Willow Wood neighborhood revealed: *On the floors inside the door, along the left and right walls, were multiple cardboard boxes of opened and unopened supplies that lined the entire length of both walls. *Between the two walls, adjoined a countertop with a sink and cupboards that were blocked with opened and unopened cardboard boxes of supplies on the floor. *Some opened cardboard boxes contained toilet paper, hand soap, and chemicals. *The countertop sink and cupboards were also blocked by a black three-shelf cart on wheels that had a piece of masking tape posted on the middle shelf that read: "MAINTENANCE". *The black wheeled cart was cluttered with cans of paint, green hose, cardboard boxes, a pink bin that stored light bulbs, and other unidentified maintenance	F0880		

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F0880 SS = E	Continued from page 42 supplies. *The countertops next to the sink were cluttered with used paint supplies and other items. *The left countertop stored used paint brushes, paint sticks, paint cans, rollers, roller handles, plastic bags, chemicals, a spray bottle of paint, a package of peri-wipes, and a large box of trash liners. *The right countertop stored used paint containers, paint sticks, paint pans, and a stack of white paint sheets. *The sink contained used paint pans and containers with dirty paint supplies stored in them. -The sink and the wall behind the sink were soiled with dried tan paint and covered with a white film. *There was trash, cardboard, and empty spray bottles on the floor. *The floor was visibly soiled with dirt, lint, and paint fibers. 8. Observation on 12/17/25 at 2:54 p.m. in the dirty utility room on the Plum Creek neighborhood revealed that the protective shield for the hopper (a type of flushing sink with a spray hose nozzle used for rinsing soiled laundry prior to washing) was not attached. It was sitting on the floor underneath the handwashing sink. There was no personal protective equipment (PPE), such as aprons, face shields, and gloves, available in the dirty utility room for staff to use if they needed to rinse soiled laundry. 9. Observation on 12/17/25 at 2:54 p.m. in the Plum Creek neighborhood clean utility closet revealed there were at least two containers of germicidal wipes that were expired. One container of "Micro-Kill Bleach" wipes were open to air and the wipes were dry. That expiration date was 12/11/24. Another container of "SANI-CLOTH BLEACH" wipes was also open to air and dry, with an expiration date of "03/2024." 10. Observation and interview on 12/17/25, starting at 3:00 p.m. with assistant director of nursing (ADON) C in the clean and soiled utility rooms of Plum Creek and Willow Wood neighborhoods revealed:	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

(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
F0880 SS = E	Continued from page 43 *She stated it was the maintenance and housekeeping's responsibility to maintain and keep those areas organized and clean. *She confirmed that the clean and soiled utility rooms in both neighborhoods were cluttered, unkept, and could pose safety risks for staff. *She expected that all utility rooms in the neighborhoods should be organized, well-maintained, and cleaned by the maintenance and housekeeping departments. 11. Observation on 12/17/25 at 3:01 p.m. in the Plum Creek neighborhood dry storage room revealed several cases of the green aloe hand sanitizer that had an expiration date of July 2024. There were other various partially used bottles of hand sanitizer that had all expired over a year ago. 12. Observation on 12/17/25 at 3:07 p.m. in the hallway between the Plum Creek neighborhood clean utility, dirty utility, and dry storage rooms revealed there was a plastic set of drawers. It appeared to have been a transmission-based precaution supply kit that contained personal protective equipment and signage for enhanced barrier precautions. There was a container of "Micro Kill AF2" wipes with a "Best By" date of 9/3/25. 13. Observation on 12/18/25 at 9:46 a.m. in the kitchen revealed there were at least two bottles of green aloe hand sanitizer, one with an expiration date of April 2025, and the other with an expiration date of September 2024. 14. Interview on 12/17/25 at 3:24 p.m. with ADON C revealed that the automatic hand sanitizer dispensers were managed by the maintenance department. She said, "I would like to tell you there's a process for checking expiration dates, but there isn't one." She confirmed there was no set process to check the expiration dates on the hand sanitizers or germicidal wipes. She was not aware of the expired hand sanitizer bottles throughout the Plum Creek neighborhood. She expected staff to check the product dates before using it, and to discard the product and find a replacement if the product was expired. 15. Interview on 12/18/2025 at 10:57 a.m. with	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

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F0880 SS = E	Continued from page 44 maintenance supervisor E and housekeeping O revealed: *They both agreed and confirmed that the clean and soiled utility rooms in both neighborhoods were cluttered, unkept, and could pose safety risks for staff. *They both agreed that it was the maintenance and housekeeping staff's responsibility to keep those areas maintained, organized, and clean. 16. Interview on 12/18/2025 at 11:18 a.m. with director of nursing (DON) B revealed: *She stated it was the maintenance and housekeeping's responsibility to maintain and keep resident rooms and all facility areas organized and clean. *She expected that all resident rooms and utility rooms in the neighborhoods should be organized, well-maintained, and cleaned by the maintenance and housekeeping departments. Review of the provider's 10/16/25 Infection Prevention and Control Committee policy revealed: *"1. The objectives of the infection prevention and control program (IPCC) are to:" -".b. provide facility guidelines for a safe and sanitary environment;" -"c. review, establish, and monitor environmental infection prevention and control practices in accordance with CDC/HICPAC/OSHA guidelines and local or state requirements;" *".....8. Assist in monitoring and assessing facility-wide environmental infection prevention and control practices." *"....13. Collaborate with environmental services director to establish policies and procedures that are consistent with environmental infection prevention and control best practices." *"Risk Exposure Categories: The infection prevention and control committee shall advise the administrator about working conditions and specific tasks that employees are expected to encounter that may pose an infection risk, including:"	F0880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 45 -"b. developing, or supervising the development of, standard operating procedures (SOPs) for tasks involving exposure to blood/body fluids. These SOPs include mandatory work practices and protective equipment for identified tasks. -"c. monitoring the effectiveness of work practices and protective equipment. This includes:" --"(1) surveillance of the workplace to ensure that required work practices are observed and that protective clothing and equipment are provided and properly used." Review of the provider's January 2025 Maintenance Service policy revealed: *"Policy Interpretation and Implementation." -"1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times." -"2. Functions of maintenance personnel include, but are not limited to:" -".b. maintaining the building in good repair and free from hazards." -".....i. providing routinely scheduled maintenance service to all areas." -"..5. Maintenance personnel shall follow established infection control precautions in the performance of their daily work assignments. -"6. The maintenance director is responsible for maintaining the following records/reports:" -".b. Work order requests." -"7. Records shall be maintained in the maintenance director's office." -"8. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned."	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	**3012 E ASPEN BLVD , BRANDON, South Dakota, 57005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 12/16/25. Bethany Home - Brandon 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
Hunter Winkleplack	Administrator	01/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN B. WING	(X3) DATE SURVEY COMPLETED 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	3012 E ASPEN BLVD , BRANDON, South Dakota, 57005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	INITIAL COMMENTS A recertification survey was conducted on 12/16/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Bethany Home - Brandon 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 K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, measurement, and interview, the provider failed to maintain automatic fire sprinkler system coverage for three randomly observed locations (Maple Village linen closet, north employee entrance,	K0353	A new sprinkler head was installed in the IT room on 12/31/2025. The Environmental Services Director and sprinkler contractor will clear the birds nest from the exterior sprinkler identified on 01/15/2026 and ensured that the other listed sprinkler heads were also free from obstruction. Beginning 01/19/2026, the Environmental Services Director, or designee, will audt facility sprinkler heads to ensure they are free from obstruction 3x per week x4 weeks, 2x per week x4 weeks, and 1x per week x4 weeks. The Environmental Serivces Director, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	02/01/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hunter Winkleplack	Administrator	01/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435130	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN** B. WING	(X3) DATE SURVEY COMPLETED **12/16/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0353 SS = E Bldg. 01	Continued from page 1 and IT closet). Findings include: 1. Observation on 12/16/25 at 11:17 a.m. revealed a sprinkler head in the northeast linen storage closet in the corridor in Maple Village was obstructed by pillows on a storage shelf. Those pillows were approximately only 8 inches below the bottom of the sprinkler head deflector. That shelf and those items would interrupt the proper discharge and operation of the sprinkler head. Interview with the maintenance manager at the time of the observation revealed he was not aware of the obstructed sprinkler head. 2. Observation on 12/16/25 at 11:42 a.m. revealed the exterior sprinkler head covering the overhang at the north employee entrance was obstructed by a bird's nest. That bird's nest almost completely engulfed the sprinkler head and would interrupt the proper discharge and operation of that sprinkler head. Interview with the maintenance manager at the time of the observation revealed he was not aware of the obstructed sprinkler head. 3. Observation on 12/16/25 at 2:28 p.m. revealed the IT room was not provided with any sprinkler heads. Sprinkler heads are required in every room of the facility to maintain full automatic fire sprinkler system coverage. Interview with the maintenance manager at the time of the observation revealed he was not aware that location was not provided with any sprinkler heads.	K0353		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10677-2	A. BUILDING: _____ B. WING _____	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/16/25 through 12/18/25. Bethany Home - Brandon was found not in compliance with the following requirements: S290 and S301.	S 000		
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods to meet planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of the facility's emergency preparedness plan. A facility may use military meals ready to eat and dried milk in an emergency event according to the facility's emergency response plan. This Administrative Rule of South Dakota is not met as evidenced by: Based on menu review, observation, interview, and policy review, the provider failed to maintain an additional supply of food sufficient for emergency purposes. Findings include: 1. Observation on 12/16/25 from 8:51 a.m. to 9:40 a.m. during the initial kitchen tour revealed that there was no additional supply of nonperishable foods designated for emergency purposes. The nonperishable foods in the dry storage appeared to have been part of the normal planned menu. 2. Review of the provider's emergency menu signed by the contracted dietitian on 12/17/25 revealed a three-day menu plan.	S 290	On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures related to Emergency Food Supply. On 01/13/2026, the Dietary Director placed an order for the items necessary to ensure the facility had its required Emergency Food Supply on hand. All staff will be educated via in-service by 02/01/2026 regarding the policies and procedures related to Emergency Food Supply. Beginning 01/19/2026, the Dietary Director, or designee, will audit that the emergency menu is on hand 1x per week for 90 days. The Dietary Director, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	02/01/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 01/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10677-2	A. BUILDING: _____ B. WING _____	12/18/2025

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S 290	Continued From page 1 Breakfast on Day 1 consisted of juice, dry cereal, canned fruit, peanut butter cookies, pudding, and reconstituted canned or dry milk. Lunch on Day 1 consisted of canned beef stew, canned green beans, pudding, bread, and a beverage. Dinner (the evening meal) of Day 1 consisted of a chicken sandwich, canned baked beans, canned fruit, vanilla wafers, and reconstituted canned or dry milk. Breakfast on Day 2 consisted of juice, dry cereal, canned fruit, a peanut butter and jelly sandwich, and reconstituted canned or dry milk. Lunch on Day 2 consisted of corned beef hash, canned peas and carrots, canned fruit, assorted cookies, bread, and a beverage. Dinner on Day 2 consisted of a tuna sandwich, canned green beans, pudding, and reconstituted canned or dry milk. Breakfast on Day 3 consisted of juice, dry cereal, canned fruit, peanut butter cookies, pudding, and reconstituted canned or dry milk. Lunch on Day 3 consisted of canned chili, canned peas and carrots, pudding, bread, and a beverage. Dinner on Day 3 consisted of canned chicken, canned green beans, canned fruit, bread, assorted cookies, and constituted canned or dry milk. 3. Interview on 12/18/25 at 10:11 a.m. with dietary manager D revealed that she confirmed they did not have the food items on the emergency menu in stock in the facility. She said that she was aware of the state administrative rule regarding the emergency food supply. When asked why they did not have the emergency food supply, she indicated that she ordered food from their supplier twice per week,	S 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10677-2	A. BUILDING: _____ B. WING _____	12/18/2025

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S 290	Continued From page 2 and they received those food orders twice per week. She confirmed they had enough food on hand for three days of their planned menu. She said that they also have access to the local grocery store and a local catering company. When asked if there was a contract or memorandum of understanding (MOU) with the catering company to provide meals in an emergency situation, she said that they did not have anything like that. 4. Interview on 12/18/25 at 12:37 p.m. with administrator A revealed that he was not aware that there was no emergency food supply on hand according to the emergency menu plan. It was his expectation that there should have been a supply of food designated for emergency purposes. 5. Review of the provider's 2023 Emergency Disaster Planning policy from the provider's diet manual revealed the policy statement read, "The facility will have a written emergency preparedness plan that complies with federal, state and local laws and is evaluated annually. ...The facility's written emergency preparedness plan will include emergency water and food needs." "Procedure: The following will be available during an emergency or disaster: 1. Emergency food, water and supplies for the planned menu pattern for a minimum of 3 to 7 days. This should include adequate water for patients/residents, staff and additional people (such as family members, rescue workers, and evacuees). The menu should consist of familiar foods, comfort foods if able, and be palatable even if it is repetitious. Food that can be transported in case of an evacuation should be	S 290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10677-2	A. BUILDING: _____ B. WING _____	12/18/2025

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S 290	Continued From page 3 available ..."	S 290		
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 interview, record review, and policy review, the provider failed to ensure two of three reviewed dietary employees (dietary aide [DA] T and DA U) completed their required dietary orientation training within 30 days of their hire dates. Findings include: 1. Review of DA T and DA U's personnel files revealed DA T's hire date was 10/30/25 and DA U's hire date was 11/11/25. There was no documentation either of them had completed the required dietary orientation training within 30 days of their hire dates.	S 301	On 01/12/2026, IDT, in collaboration with the facility medical director, reviewed and revised, as necessary, the policies and procedures relating to Dietary In-Service Training requirments. DA T and DA U received their initial dietary aide training on 12/19/2025 and 12/20/2025 respectively. On 12/29/2025, the Dietary Director reviewed employee records to ensure that all dietary staff had their required training completed. DM D, DA T, DA U and all staff will be educated via in-service by 02/01/2026 regarding the policies and procedures related to required dietary staff training. Beginning 01/19/2026, the Dietary Director, or designee, will audit that all new dietary staff have their required training completed within their first 30 days 1x per week for 90 days. The Dietary Director, or designee, will present the findings of the audit to the QAPI committee at their quarterly meeting for review and recommendation.	02/01/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 301	Continued From page 4 2. Interview on 12/17/25 at 2:00 p.m. with administrator A confirmed the above finding. He stated it was the responsibility of dietary manager (DM) S to ensure that dietary training had occurred. 3. Interview on 12/17/25 at 2:30 p.m. with DM D revealed other dietary responsibilities prevented her from ensuring DA T and DA U's dietary orientation training was provided within 30 days of their hire dates. She confirmed neither of those dietary staff had completed their required dietary orientation training. Review of the provider's January 2025 Dietary Training policy revealed: *"1. All new Dietary Staff members will receive training on the following topics within 30 days of hire: -a. Food Safety; -b. Handwashing; -c. Food handling and preparation techniques; -d. Food borne illnesses; -e. Serving and Distribution procedures; -f. Leftover food handling procedures; -g. Time and temperature controls for food preparation and service; -h. Nutrition and hydration; -i. Sanitation requirements."	S 301		