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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 000	INITIAL COMMENTS	F 000		

A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/5/24 through 11/8/24. Bethany Home - Brandon was found not in compliance with the following requirements: F583, F585, F610, F641, F801, and F812.

A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/5/24 through 11/8/24. Areas surveyed included staff termination due to intoxication and resident safety related to the use of mechanical lifts. Brandon Home - Brandon was found not in compliance with F610.

On 11/7/24:
*At 8:58 a.m., immediate jeopardy was identified related to failure to maintain the manufacturer's specification for the dishwashers' rinse cycle temperatures of a minimum of 180 degrees Fahrenheit at F812.

*At 11:55 a.m. notice of immediate jeopardy was provided verbally and in writing to Admin A and DON B. An immediate jeopardy removal plan was requested at that time.

*At 1:31 p.m. Admin A provided their removal plan for the immediate jeopardy.
*At 2:17 p.m. the provider's removal plan was accepted by the survey team.
*At 4:07 p.m. the on-site survey team reviewed the provider's documentation for the removal of the immediate jeopardy and determined the immediacy was removed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 12/05/2024

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

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F 000	Continued From page 1 After the removal of the immediate jeopardy, the scope and severity of the citation level was "F" with guidance from the long term care advisor for the South Dakota Department of Health. The resident census was 52.	F 000		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws.	F 583	All Bethany owned monitoring devices will be removed from resident rooms as of 12/02/2024. Resident care plans will be reviewed by 12/10/2024 to ensure that any monitoring devices are included in their care plans. All facility rooms will be audited on 12/02/2024 to ensure no video or audio monitoring devices are in place and not accounted for. IDT, in collaboration with the Medical Director, reviewed and revised the policies and procedures, as necessary, relating to monitoring devices and resident privacy and confidentiality on 11/27/2024. CNA L, CMA I, CMA J, CMA K, NA W, Housekeeper X, CNA/CMA Y, and all staff will be educated via in-service on 12/04/2024 regarding the policies and procedures related to monitoring devices and resident privacy and confidentiality. Beginning 12/02/2024, DON, or designee, will audit that all residents with video monitoring devices have proper signage outside of their room 2x per week for 3 months. Beginning 12/02/2024, DON, or designee, will audit that consents for video monitoring are in place for all residents with those devices 2x a week for 3 months. Beginning 12/02/2024, DON, or designee, will audit that resident care plans are updated to reflect any visual monitoring devices in use 2x a week for 3 months. DON, or designee, will present the findings of the audit to the QAPI committee for rview and recommendation at their quarterly meeting.	12/10/2024

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F 583	Continued From page 2 (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to: *Ensure privacy had been maintained during interviews conducted in resident rooms for 13 of 13 (2, 13, 19, 21, 22, 27, 28, 41, 47, 48, 49, 52, and 106) residents with audio and video monitoring devices in their rooms. *Obtain consent for audio and video monitoring use for 6 of 13 (13, 41, 47, 49, 52, and 106) residents with audio and video monitoring devices in their rooms. Findings include: 1. Observation and interview on 11/05/24 at 1:27 p.m. with resident 28 in his room revealed: *An iFamily audio/video camera was on top of his closet facing his recliner. *He was unable to identify the audio/video device in his room. -He was conversive but unable to answer questions about the audio/video monitoring device. *There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. 2. Observation and interview on 11/05/24 at 2:22 p.m. and again on 11/08/24 at 8:36 a.m. with resident 22 in his room revealed: *An iFamily audio/video camera was on the bedside table next to the lamp. *He was unable to identify the audio/video device	F 583		

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F 583	Continued From page 3 in the room. *An "Echo Dot" device [a smart speaker with an internet connection and a drop-in feature that allows instant connection between connected devices] was located between 2 recliners. *There was no sign at the entrance to the room or within the room that indicated audio/video monitoring devices were used in that room. 3. Observation and interview on 11/05/24 at 2:36 p.m. with resident 13 in his room revealed: *An iFamily audio/video camera was located on his nightstand. *He was unable to identify the audio/video device. -"I don't know what that is." *There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room. Review of resident 13's electronic medical record revealed (EMR): *There was no documentation that resident or family consent was obtained for the use of the audio/video monitoring device. *There was no documentation that the care plan had been updated to reflect the use of the audio/video monitoring device. 4. Observation and interview on 11/05/24 at 3:18 p.m. with certified nursing assistant (CNA) L in resident 106's room revealed: -CNA L sat on resident 106's bed visiting with her because "she keeps trying to get up and walk." *A white monitoring device was on the windowsill. -CNA L stated that it was an audio-only device. *CNA L confirmed that other devices in the facility had video cameras, but this one did not. *There was no sign at the entrance to the room or within the room that indicated an audio monitoring	F 583		

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F 583	Continued From page 4	F 583		

device was used in that room.

Review of resident 106's EMR:
*There was no indication that resident or family consent was provided for the use of the audio device.
*There was no indication that the care plan had been updated for the use of the audio device.

Observation on 11/6/24 at 8:19 a.m. of resident 106's room revealed that the audio monitoring device was no longer present in that room.

5. Observation and interview on 11/05/24 at 3:29 p.m. with resident 19 in his room revealed:
*He had an Echo Dot device he called "Alexa" in his room.
-His son had helped him set it up.
-He used it to control his television.
*There was no sign at the entrance to the room or within the room that indicated an audio monitoring device was used in that room.

6. Observation and interview on 11/6/24 at 9:55 a.m. with resident 41 and her husband in her room revealed:
*Her room was located on the provider's secure Memory Care Unit (MCU).
*There was no sign at the entrance to the room or within the room that indicated an audio/video monitoring device was used in that room.
*A family interview was conducted with the resident and her husband in this room with the expectation of privacy.

Observation on 11/8/24 at 8:43 a.m. of resident 41's room revealed:
*No signage at the entrance to the room or within the room that indicated an audio/video monitoring

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F 583	Continued From page 5 device was used in that room. *An audio/video monitoring device, "HelloBaby," sat on her dresser in the room with the camera pointed toward the room. Review of resident 41's EMR revealed: *There was no documentation resident or family consent was obtained for the use of an audio/video monitoring device. *There was a handwritten and undated care plan intervention, "I have a camera in my room to help monitor my safety as well as to monitor other residents who may wander in my room." 7. Observation and interview on 11/7/24 at 4:21 p.m. with resident 27 and certified medication aide (CMA) I in resident 27's room revealed: *An iFamily audio/video camera was on the shelf in her room. -The camera had both audio and video functions. *She had turned the camera away from her while assisting resident 27. *An Echo Show device was located on her nightstand between the recliner and the bed. -That device was provided by resident 27's family. -CMA I stated that resident 27's family used that device to talk to other family members when they visited. -CMA I was unaware if that device allowed the family to listen or watch the care provided. *She would have known which resident rooms had a "video camera" because it was on their "daily worksheet.". *There was no sign at the entrance to the room or within the room that indicated audio/video monitoring devices were used in that room. Observation and interview on 11/7/24 at 4:30 p.m. with CMA I at the Cotton Wood Court	F 583		

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F 583	Continued From page 6 neighborhood nurse's station revealed: *The audio/video monitoring screen was positioned facing into the nurse's station. -That screen was visible when facing the nurse's station when you looked to the right side. -That screen could have been seen by a public visitor when standing at the nurse's station. *CMA I confirmed that this device was used by resident 27 because "she is the only one in this neighborhood with a camera." *CMA I confirmed that the cameras are listed on the resident care plan. *She stated that all staff who walked by should watch to make sure that resident 27 did not have a fall. -The audio/video monitoring camera and screen remained on even when the resident was not in their room. *She demonstrated the audio and "pan and tilt" features of the audio/video camera. -The camera viewing angle in resident 27's room was changed with the use of the control features of the monitoring screen at the nurse's station. -That allowed the viewing angle of the camera inside the resident's room to be remotely changed from outside the room. 8. Review of the provider's neighborhood daily worksheets revealed: *The "Cotton Wood Report Sheet" was undated. -It did not indicate that resident 27 had an audio/video monitoring device. *The "Willow Wood Way Pocket Guide" was undated. -It did not indicate that residents 2, 13, and 22 had audio/video monitoring devices. *The Plum Creek Pocket Guide" was updated on 11/7/24. -It did not indicate that residents 19, 28, and 106	F 583		

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F 583	Continued From page 7	F 583		

had video or audio monitoring devices.
*The "Maple Valley Report Sheet" was undated.
-It indicated residents 21, 41, 47, 49, and 52 had a "*Camera" in their rooms.
-Related to resident 48 it indicated "FYI- CAMERA IN ROOM FROM FAMILY - THIS DOES RECORD."

9. Observation on 11/08/24 at 8:13 a.m. of the Plum Creek nurse's station revealed:
*One audio/video monitoring screen on the counter facing the nurse's station.
-There was no indication as to which resident room was being displayed.
-That screen was visible when facing the nurse's station when you looked to the right side.
-That screen could have been seen by a public visitor when standing at the nurse's station.
*The audio/video monitoring device had a pan and tilt feature that allowed the viewing angle of the camera inside of the resident's room to be remotely changed from outside the room.

Interview on 11/08/24 at 8:26 a.m. with CMA J regarding the audio/video monitoring devices used on Plum Creek revealed:
*Resident 28 and resident 106 had "video cameras" in their rooms.
-They were both the same kind.
*The viewing monitor was kept at the nurse's station, but it could have been unplugged and carried by staff when needed.
-All staff were responsible for looking at the audio/video monitoring screen at the nurse's station for resident safety.
*She would have known which residents had "video cameras" in their rooms "because they are in the room, and I can see them."
*She was unaware if any family-provided audio or

F 583 Continued From page 8 F 583

monitoring devices had been used in that neighborhood.

Observation and interview on 11/08/24 at 8:41 a.m. with CMA K at the Willow Wood Way neighborhood nurse's station revealed:
*Two audio/video monitoring screens faced the nurse's station.
-One was labeled "keep vol [volume] on".
-There was no indication of which residents' rooms were monitored.
-Those screens were visible when facing the nurse's station when you looked to the left side.
-Those screens could have been seen by a public visitor when standing at the nurse's station.
-The audio/video monitoring device remained on even when the resident was not in their room.
*CMA K stated the audio/video monitors were used for resident 22 and resident 13.
-The video cameras were used as fall interventions on their care plans.
-All staff were responsible for implementing fall interventions.
*The audio/video monitoring device had a pan and tilt feature.
-This allowed the viewing angle of the camera inside the resident's room to be remotely changed from outside the room.

10. Observation on 11/8/24 at 8:33 a.m. of resident 49's room revealed:
*His room was located on the Maple Valley wing on provider's secure MCU.
*There was a "HelloBaby" audio/video device plugged in and sitting on his four-drawer dresser in front of his flat screen television.
*There was no signage on his door or in his room that indicated an audio/video device was in his room.

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F 583	Continued From page 9	F 583		

Review of resident 49's EMR revealed:
*There was no documentation resident or family consent was obtained for the use of an audio/video monitoring device.
*There was a handwritten and undated care plan intervention "I have a camera in my room to promote my safety."

11. Observation on 11/8/24 at 8:36 a.m. of resident 47's room revealed:
*Her room was located on the Maple Valley wing on the provider's MCU.
*There was a "vtech" audio/video monitoring device plugged in with a "MIC [microphone]" and the indicator light that was on and green, which indicated the device was on.
*Her room door had no signage that indicated audio/video monitoring.

Review of resident 47's EMR revealed there was no documentation resident or family consent was obtained for the use of an audio/video monitoring device.

12. Observation and interview on 11/8/24 at 8:40 a.m. with resident 52's husband and of her room revealed:
*Her room was located on the Maple Valley wing in the MCU.
*She and her husband were in the room and he was aware of the audio/video monitoring with no concerns expressed.
*He stated the purpose of the device was related to his wife's falls and to keep her safe so the staff could respond if she falls.
*Her room door had no signage that indicated audio/video monitoring.

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F 583	Continued From page 10 Review of resident 52's EMR revealed there was no documentation resident or family consent was obtained for the use of an audio/video device. 13. Observation and interview on 11/08/24 at 8:56 a.m. with resident 2 in her room revealed: *An audio/video communication device with a screen she called a "portal" was on her nightstand next to her recliner. *She stated she used the device to talk to her family. -"I just say 'hey portal' call whoever I want to call." *She stated it also rang "like a telephone," but she could answer it with her voice. *She stated she could see her family on the screen, and they could see her. *There was no sign at the entrance to the room or within the room that indicated an audio/video device was used in that room. 14. Interview on 11/8/24 at 8:55 a.m. with nursing assistant (NA) W revealed she: *Was recently hired on 10/8/24 and was training to be a CNA. *Was aware of audio/video monitoring in some of the residents' rooms. *Stated the audio/video monitoring had not been discussed at the facility's new employee orientation she had attended. *Became aware of the audio/video monitoring when she saw the video monitors at the nursing station's desk. *Stated "At least three [residents] have it in their room." Continued interview on 11/8/24 with NA W revealed that the audio and video monitor was on for resident 41's device and stated staff "can't really hear it, unless we turn it up."	F 583		

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F 583	Continued From page 11	F 583		

15. Observation on 11/8/24 at 9:00 a.m. of the nursing station in the provider's MCU revealed five audio/video monitoring units were located on the nurses' station desk area with their screens on and turned toward the kitchenette area.

16. Interview and observation on 11/8/24 at 9:08 a.m. with housekeeper X in Maple Valley MCU revealed she:
*Had been working at the facility for seven months.
*Stated she was aware of the video monitoring in some of the resident rooms.
*Showed this surveyor resident 48's room that had a video camera placed on top of the resident's wardrobe aimed at her bed.
*Noted a pink sign on the resident's wardrobe that stated "Video Monitoring/Recording in Progress. Please do not Move Camera per Family Request."
-She stated today was the first day she noticed that sign on her wardrobe.
-She stated she was not aware of all the rooms that had audio/video monitoring but said video monitoring cameras were in some of the resident rooms in other wings.
*Could not recall if the audio/video recording had been discussed during her new employee orientation.
*Showed this surveyor resident 21's room in the MCU and the "iFamily" video camera on her dresser and agreed there was no sign displayed of the audio/video monitoring.

17. Interview on 11/8/24 at 9:15 a.m. with CNA/CMA Y revealed:
*There were five facility placed audio/video monitors in the MCU.

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F 583		F 583		

Continued From page 12

*The audio/video monitors were used by staff to watch for the residents who would rise from their beds at night as a fall prevention.
*The staff would also make rounds every couple of hours in the resident wings.
*Resident 48's family had placed a video camera in her room.
*The facility placed audio/video monitors were not recording devices.
*The audio/video monitors all had audio so the staff could also hear what was occurring.

18. Interview on 11/8/24 at 9:41 a.m. with RN G revealed she:
*Was the MCU's neighborhood leader.
*Stated the audio/video monitoring was used as an intervention for falls.
*Pointed to where the audio/video monitors were located on the nursing station desk and stated residents did not typically come into the nurse's station area.
*Agreed the audio/video monitoring had occurred during the time of the family interview with resident 41 and her husband on 11/6/24.
*Stated staff informed and cleared the audio/video monitoring with the family but did not ask the family to sign an acknowledgment of the monitoring.
-That family conversation would be noted in a progress note.
-Audio/video monitoring was included in the resident's individual care plan.
*Stated "It's a thought" when asked if the provider should have signage posted for the audio/video monitoring.

19. Interview on 11/08/24 at 11:30 a.m. with administrator A regarding the provider's privacy policy revealed:

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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BETHANY HOME - BRANDON	**3012 E ASPEN BLVD BRANDON, SD 57005**

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F 583 | F 583

Continued From page 13

*They reviewed resident rights at admission and residents would sign an acknowledgment at that time.
*The resident admission packet was provided to the survey team during the entrance conference.
-All information covered during a resident's admission would be found there.
*There was no specific privacy policy.
-The residents' right to privacy was covered in that admission packet.

20. Observation and interview on 11/08/24 at 11:50 a.m. with DON B regarding the use of audio/video monitoring devices revealed:
*The provider used audio/video monitoring devices in several residents' rooms.
-There were several different brands of devices.
-All the devices used had audio and video capabilities.
*Audio/video monitoring devices were used as a fall intervention.
*The interdisciplinary team (IDT) reviewed residents to determine the need for an audio/video monitoring device.
*Audio/video monitoring devices not being used were stored in the DON's office or the nurse's storage room.
-All nursing staff and maintenance had access to the nurse's storage room where the extra audio/video monitoring devices were kept.
-It was confirmed that there were no devices in the nurse's storage room.
*There was one audio/video monitoring device in the DON's office.
-That device had been removed from resident 106's room because "it should not have been in that room".
-"It [the audio/video monitoring device] must have been left at the nurse's station when a different

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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F 583	Continued From page 14 resident discharged." -She was "looking into how it got there [resident 106's room]." *She kept a list of residents who had audio/video monitoring devices. -Resident 106 was not on that list. *She expected that the family would have been notified and consent would have been obtained when the audio/video monitoring device was recommended by the IDT. -Those devices should have been added as an intervention to each resident's care plan who had one in their room. *Family members had provided other devices including Alexa and Echo devices to residents. -They were to be added to the care plan. *She confirmed that they had not posted any notice in the resident's room about audio/video monitoring devices used in those rooms. *She had not considered the need for privacy during interviews with residents and their families conducted by the survey team or when residents visited with family or other visitors. -She stated staff should turn the camera in the room while providing care. Interview on 11/08/24 at 11:59 a.m. with DON B regarding resident consent and care plans revealed: *They did not use a "consent form" for audio/video monitoring devices in residents' rooms. *Staff would have documented in the resident's EMR when families would have been notified of the use of an audio/video monitoring device as a fall intervention. *She had provided a copy of "all the notifications to families" for residents with an audio or video monitoring device that had been completed.	F 583		

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F 583	Continued From page 15	F 583		

-She confirmed that she had been unable to locate notifications to the family for residents 13, 41, 47, 49, 52, and 106.
*She confirmed that the care plan had not been updated for resident 13.
*She stated resident 106's care plan would not have been updated, because resident 106 had not been reviewed by the IDT for audio/video monitoring device use.

21. Review of the provider's un-dated Resident Admission Packet revealed:
*ADMISSION ACKNOWLEDGEMENTS."
-"The undersigned resident/responsible party acknowledges receipt of the following information. Check the list below."
--"Resident Bill of Right."
*A consent form, "8. BETHANY HOME PATIENT & RESIDENT RIGHTS: I have received a copy of the Bethany Home Patient & Resident Rights form and understand it."
*"PRIVACY ACT STATEMENT- HEALTH CARE RECORDS."
-"THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PROVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM ..."
*A South Dakota State Long-Term Care Ombudsman Program packet.
-"You have the right to privacy and confidentiality regarding personal, financial, and medical affairs ..."
--"A facility must permit you to: ... 2. Use a telephone without being overheard .... 7. Meet with people in a private setting within the facility.

22. Review of the iFamily Baby Monitor SM650 User Manual revealed:
*"PAN AND TILT The camera unit can be remotely controlled from the Monitor Unit."

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F 583	Continued From page 16 *"Volume +/ Up key: Press Volume+ to increase the volume .... Review of the provider's 2/1/24 Video/Audio Monitoring and Recording policy revealed: *"This policy outlines the rules for deploying such devices to ensure security, safety and the protection of resident's privacy." *"Bethany allows the use of video monitoring on the campus.' *"Management, residents or their authorized representatives may place video monitoring devices in residents' rooms. *"Placement of Monitoring Devices owned by Bethany" -"Bethany may place video monitoring devices in resident's rooms/apartments if deemed appropriate and approved by the Administrator, or designee, and agreed upon by the resident or their authorized representative." -"Monitoring devices placed in residents' rooms/apartments should be positioned to minimize the monitoring of "private areas" such as restrooms, bathing areas, and the changing areas as much as possible." *"Resident Owned Monitoring." -"Before initiating video monitoring, a resident shall provide notice and consent to Bethany. *The policy did not identify a need to post notices at the entrance to the resident's room that a monitoring device was operational in that room. *The policy did not identify a need to obtain consent for the placement of monitoring devices owned by Bethany..	F 583		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances.	F 585	Beginning 12/02/2024, Administrator A will meet with resident 20 and resident 41 and their husband to begin a formal grievance procedure for the concerns listed in the report. IDT, in collaboration with the Medical Director,	12/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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F 585

Continued From page 17

§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her

F 585

reviewed and revised the policies and procedures relating to the resident grievance procedures and the definitions of major and minor concerns within those policies on 11/27/2024.

Life Enrichmen Director F, Social Services Director C, and all staff will be educated and trained via in-service on 12/04/2024 regarding the policies and procedures related to resident grievances and their roles and responsibilities when residents and/or the resident representative bring a problem forward.

Beginning 12/02/2024, Social Services Director will keep a log of all resident grievances that are brought forward which will include the date the grievance was received, a summary of the statement of the resident grievance, the steps taken to investigate the grievance, a summary of of pertinent findings or conclusions regarding the resident's concerns, a statment as to whether the grievance was confirmed, any corrective action taken, and the date the written decision was issued back to the resident or their representative.

Beginning 12/02/2024, Administrator, or designee, will audit that all resident grievances are properly followed up with according to policy 2x a week for 3 months.

Administrator or designee will present the data included in the log to the QAPI committee for review and recommendation at their quarterly meeting.

IDT, in collaboration with the Medical Director, reviewed and revised the policies and procedures relating to concerns brought forward in resident council on 11/27/2024.

Life Enrichment Director F, Social Services Director C, and all staff will be educated via in-service on 12/04/2024 regarding the policies and procedures relating to concerns brought forward in resident council.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 585	Continued From page 18 grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;	F 585	Beginning 12/02/2024, Administrator, or designee, will audit that resident council concerns are followed up with through a completed form and that those concerns and their responses are reflected in the next month's minutes 1x per month for 3 months. The Administrator, or designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585

Continued From page 19

F 585

(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to implement an effective grievance process to ensure a resident's right to file grievances included documentation, investigation, and follow-up with the resident and the resident's representative's grievances regarding issues of resident care and quality of life that were important to the resident. That failure had the potential to affect all 52 residents.

Specifically, the provider failed to ensure the following:
*All written grievance decisions included the date that the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to have been taken by the provider as a result of the grievance, and the date the written decision was issued.
*Maintenance of grievance documentation for a period of no less than three (3) years from the

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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F 585	Continued From page 20	F 585		

issuance of the grievance decision.
*Prompt efforts to resolve grievances and to have kept the residents informed of progress toward the resolution.
*Staff completed a grievance form if given an oral grievance, investigated and followed up with the resident and their representative.
*The resident council was informed in writing of the responses to concerns brought up in the resident council meetings and provided a prompt update on efforts by the provider to resolve any grievances.
Findings include:

1. Interview on 11/5/24 at 2:29 p.m. with resident 20 revealed she:
*Had lived at the facility for the past three years.
*Had concerns regarding the food served to the residents.
-Those concerns happened routinely enough to be significant.
-She stated there were other residents who had food concerns.
-Her food concerns had been "Since I've been here ..." and had not been addressed.
*She had voiced those food concerns:
-To staff.
-At the monthly resident council meeting.
-At her care plan conferences.

2. Interview on 11/6/24 at 9:55 a.m. with resident 41 and her husband revealed he had some concerns regarding:
*"The other day" he had purchased some items at the provider's BINGO store and had placed those items, including deodorant and a new toothbrush, into a bag with his wife's name on it and place the bag on the chair in his wife's room.
*The next day the bag was gone.

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F 585	Continued From page 21 -He mentioned it to the housekeeper and other staff. -Staff found the missing bag in another resident's room. *"About two months ago" fish was served on Fridays for lunch. -The fish was "awful." -It happened repeatedly enough that he let the staff know about his concern with the fish served. -He had not received a resolution to his concern, but stated the last few times the fish was "wonderful." Interview on 11/8/24 at 9:47 a.m. with registered nurse (RN) G revealed: *She was the neighborhood leader for the Memory Care Unit (MCU). *She recalled the husband of resident 41 discussing his concern regarding the missing bag of items from the BINGO store. *She had not written the concern down or made a progress note regarding the concern and she felt they had investigated and resolved that concern. *When asked about how she handled concerns she stated: -"I would ask family if they want to officially fill out a grievance form." -She would not fill out a grievance form for lost clothing. -She had not filled out any grievance forms for concerns she had received. -Social services director C had filled out grievance forms. 3. Review of the 8/28/24 Resident Council meeting minutes revealed the following food concerns: *The pork chops were "too dry and tough." *More options for sandwiches and types of bread	F 585		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ____ B. WING ____	C 11/08/2024

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) COMPLETION DATE
F 585	Continued From page 22	F 585		

were requested.
*Having cottage cheese on the menu more often.
*"Bread has been ... stale."
*More variety in the desserts was requested.
*"Less green beans and peas."

Review of the 9/25/24 Resident Council meeting minutes revealed the following:
*Food concerns:
-"Pork Chops have been very tough."
-The ham "was served ... too thick to cut properly."
-The "Morning sausage has been too hard."
*Housekeeping concern that "clothing is being lost in the laundry more often."
*Activity concern that four residents attending the meeting "would like their nails done ..."
*No follow-up to the concerns raised at the August resident council meeting including the steps taken to investigate the concerns, actions taken, or the resolution was provided.

Review of the 10/29/24 Resident Council meeting minutes revealed the following:
*Food concerns:
-"Porkchops are still pretty tough to eat ..."
-More variety in salad dressings was requested.
-A preference for shredded lettuce.
-Chili "that isn't so spicy ..."
*Maintenance concern that resident 1, who attended the meeting, "wants her wheelchair fixed."
*Activity concern with three residents' nail care.
*Nursing care concerns with morning staff and "Traveling aides are not always helpful."
*No follow-up to the concerns raised at the September resident council meeting including the steps taken to investigate the concerns, actions taken, or the resolution was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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BETHANY HOME - BRANDON	**3012 E ASPEN BLVD BRANDON, SD 57005**

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F 585	Continued From page 23	F 585		

On 11/6/24 at 1:13 p.m. a request was made from administrator A for the provider's grievance log.

4. Interview on 11/6/24 at 4:28 p.m. with administrator A revealed:
*The provider had no grievances that were logged.
*Administrator A stated they had no "formal" grievances.
*For resident concerns, the staff would review the concern, investigate and work on solutions to address the issue.
*The provider did not have any written documentation to ensure the prompt effort, progress towards, and resolution of all grievances.

5. Interview on 11/8/24 at 10:27 a.m. with life enrichment director F revealed she:
*Had worked the past three years at the facility.
*Coordinated the monthly resident council meetings.
-Documented the resident concerns expressed in the meeting minutes.
-Provided the meeting minutes to the department directors.
-Stated "sometimes we get a response."
*Had not filled out a grievance form for the resident concerns expressed.
*Was not aware of any plan in place to address the residents' concern with the pork chops expressed at the August, September, and October resident council meetings.
*She had discussed "official" grievances with social services director C and she helped her fill out a grievance form.
*The last grievance was over a year ago regarding a dietary concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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BETHANY HOME - BRANDON	**3012 E ASPEN BLVD BRANDON, SD 57005**

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F 585	Continued From page 24	F 585		

6. Review of the provider's admission packet received at the start of the survey on 11/5/24 revealed an undated Resident Grievance form that included four paragraphs.

Interview on 11/8/24 at 11:30 a.m. with administrator A revealed:
*The above undated "Resident Grievance" form was the provider's "old" policy.
*He had provided the updated November 2017 Resident Grievance policy that morning, 11/8/24.

Interview on 11/8/24 at 11:32 a.m. with social services director C revealed she:
*Had worked for the past six years at the facility.
*Stated there was a difference between a concern and a grievance.
-A concern was minor and was any problem for the resident or family
-A grievance would be something more major.
*Stated not all concerns would "amount to" a grievance.
*Stated the provider had not had an "official" grievance for the past year.
*Stated resident or family concerns were discussed and forwarded to the appropriate departments but the provider did not track these concerns.

Further interview with social services director C regarding the provider's Resident Grievance policy revealed:
*The old, undated "Resident Grievance" form obtained from the admission packet at the start of the survey on 11/5/24 was the form she discussed at the time of a resident's admission.
*She was not aware of the updated November 2017 Resident Grievance policy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 585	Continued From page 25 *She agreed she was using an outdated form and she stated she would update the admission packet to include the current policy. *She confirmed they had no formal grievance tracking system. 7. Review of the provider's November 2017 Resident Grievance policy revealed: *"Grievance forms are available on each neighborhood." *"If a resident and/or resident representative has a grievance it can be written on this form." *"The form is then directed to the Social Services Office ..." *"The facility Administrator, Social Worker, Department Supervisor or Facility Designee will respond to the resident and/or responsible party in writing in a prompt manner as to their efforts to resolve the grievance." *"All grievances and facility responses will be kept on file in the Social Services Office." *"Residents may express grievances at Resident Council Meetings." *"If a grievance is voiced at the Resident Council Meeting involving specific departments, the grievance will be responded to directly by the respective Department Supervisor in a prompt manner as a follow-up at the next Resident Council Meeting." *"A resident and/or responsible party may wish to personally contact the Social Services Staff or Administrator to discuss a grievance he or she might have." *No definitions or guidance was provided regarding the difference between a concern and a grievance.	F 585		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610	IDT, in collaboration with the Medical Director, reviewed and revised, as necessary, the policies and procedures relating to incident	12/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 610	Continued From page 26 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint, interview and policy review the provider failed to thoroughly investigate an incident of an alleged certified nursing assistant being intoxicated while at work and allowed her to work the weekend following the incident. Findings include: 1. Review of the SD complaint report dated 5/7/24 revealed: *The complainant wished to remain anonymous. *She was terminated Monday 4/29/24 for suspected intoxication. *She worked an evening shift on Friday 4/26/24 but usually worked day shifts. *A beverage container had been found that smelled like alcohol in the staff break room.	F 610	investigations, facility drug testing, and the employee handbook on 11/29/2024. CNA O, CMA N, LPN R and all staff will be educated via in-serivce on 12/04/2024 regarding the policies and procedures relating to incident investigation, facility drug testing, and the employee handbook. Beginning 12/02/2024, Social Services Director or designee, will audit that investigations reported to the South Dakota Department of Health Complaints Department are completed according to regulatory requirements 2x a week for 3 months. Social Worker, or designee, will present the findings of the audit to the QAPI commitee for review and recommendations at their quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 27	F 610		

*Police were contacted and had no concerns about her being intoxicated and let her go home.
*She worked the next two days Saturday 4/27/24 and Sunday 4/28/24 without follow up from the administration.
*She had not been the one to use alcohol and the residents were still at risk and the facility needed to continue their investigation.
*She did not want her job back and had worked at the facility for five months.

2. Interview on 11/05/24 at 1:46 p.m. with resident 1 revealed:
*She is sitting in her wheelchair in her room.
*She stated things are going well here and was headed to worship and study but could talk later.
*She stated a female on night shift doesn't seem to get her brief on straight, otherwise no problems with any staff, and she was not aware of staff by name of CNA N.

3. Interview on 11/06/24 at 11:06 a.m. with resident 1 revealed:
*She had broken her leg back in March when she fell in the bathroom and could transfer herself at that time.
*She did pivot transfers with staff help now and had not had any injuries since the fall.
*She stated she heard her left shoulder crackle a couple of time when she had been assisted. "I had that replaced quite a while ago."
-She stated she is doing therapy and would see her doctor about her shoulder.

4. Interview on 11/07/24 at 4:39 p.m. with resident 1 revealed she does not use a mechanical lift, she stated, "she did that one-foot turn" [pivot transfer] with help and had no injuries or complaints about staff.

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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BETHANY HOME - BRANDON	**3012 E ASPEN BLVD BRANDON, SD 57005**

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F 610	Continued From page 28	F 610		

5. Interview on 11/08/24 at 10:46 a.m. with CNA O revealed she worked morning shifts and had never seen or heard of any staff or coworker working under the influence of alcohol. She had not seen or heard of any alcohol being in the facility staff break room. She stated if she had seen or seen that she would report that to administration.

6. Interview on 11/8/24 at 10:48 a.m. with licensed practical nurse (LPN) P revealed she was not aware that anyone had worked under the influence of alcohol, or that any alcohol had been in the breakroom but would report it if she had.

7. Interview on 11/8/24 at 3:00 p.m. with director of nursing (DON) B revealed:
*She had an incident with a staff member that was suspected of being intoxicated when she had worked 4/26/24.
-She stated that she was certified nursing assistant (CNA) Q and had picked up that 6-10 p.m. evening shift.
-She stated staff had called her around 9:45 p.m. stating that CNA Q was acting strange and that they smelled alcohol on her breath while completing cares.
-She stated she had them call the police, but Riley had left the facility.
-She stated she received report from her staff that the police had stopped CNA Q in the parking lot but a breathalyzer had not been done because the police did not think she was intoxicated as she was not stumbling when she walked and allowed her to go home.
-She stated a tumbler was found in the break room that smelled like there was alcohol in it.
-DON B stated that CAN Q did not work the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 610	Continued From page 29	F 610		

weekend and was not on the schedule.
-She stated she would get the staff schedule for that weekend.

8. Interview and review of staff schedules on 11/8/24 at 3:13 p.m. with DON B revealed:
*She stated CNA Q was on the schedule and worked Saturday 4/27/24 and Sunday 4/28/24 following the incident that happened Friday 4/26/24.
*Staff schedule indicated CNA Q had worked 6:00 a.m. to 2:00 p.m. that weekend.
*She stated, "That was a long time ago, I couldn't remember she had worked."
-She stated, "The police did not think she was intoxicated CNA Q was allowed to work."
-She stated she had asked her staff questions regarding the incident on the phone but she did not further investigate the incident.
-She had not come into the facility the night of the incident because CNA Q would have been gone by the time she would have gotten there.
-She came in 4/29/24 Monday morning and that was when she smelled the container with the alleged alcohol in it.
-She stated CNA Q was terminated 4/29/24.

9. Review of personnel consultation Termination record dated 4/29/24 revealed:
*" Name: CNA Q."
- "Category: Termination."
- "Subject: Drinking on the Job."
-" On 4/26/24 it was reported by other staff working that night that you smelled of alcohol and were behaving strangely.
"-The charge nurse approached you and informed you that you would be subject to a breathalyzer to ensure that you hand not been drinking. You then left the facility and were

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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BETHANY HOME - BRANDON	**3012 E ASPEN BLVD BRANDON, SD 57005**

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F 610	Continued From page 30 stopped by the police who offered you a breathalyzer to show you had not been drinking and you declined, and they had no reason to suspect that you had been drinking." - "On 4/29/24, Bethany Administration found a cup that is believed to belong to you and it contained a liquid that smelled of alcohol." - "As a result of these finding, Bethany will immediately be terminating your employment." - "Employee signature indicated, Employee terminated via phone, initialed by administrator A 4/29/24." - "Employee Comments had been left blank." - "Signed by human resource manager M." - "Signed by department supervisor DON B and administrator A." - "This form may be used for all types of counseling including warning records and disciplinary action records." 10. Review of SD Department of Health Facility report incident revealed: *Administrator A handed this surveyor that report and stated, "This is the investigation that was done." - "Patient/Resident name indicated resident 1 on the report." - "Cognition score was fifteen [indicated her cognition was intact]." -The report was completed and signed by administrator A. - "Date and Time of Event, 4/26/24 at 8:00 p.m." - "Type of Event Being Reported, Suspicion/allegation of abuse/neglect." - "Allegation type, Other, Suspected intoxicated employee." - "Law enforcement was notified for suspected intoxication." - "Law enforcement was notified 4/26/24 at 9:45	F 610		

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BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

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F 610	Continued From page 31 p.m." - "APS worker was notified by an emailed report for suspected resident neglect on 4/29/24 at 4:20 p.m." - "Health Department was notified on 4/20/24 at 4:20 p.m." - "Investigation Conclusion: Conclusionary summary statement of facility investigation: (Please include all specific interventions put in place to prevent further occurrences." There was no information provided. - "Suspicion/Allegation of Abuse/Neglect: Facility personnel." - "Is the individual capable of providing an explanation of the event or capable of participating in investigation? Yes." - "Provide a brief explanation of event being reported. Please include name(s) of Patient/Resident/Personnel/Family/Visitors involved with event: On 4/26/24 it was reported to the Director of Nursing that CNA Q, smelt of alcohol and that she was acting weird and disappearing for long stretches of time. Facility called the police and requested that they give the staff member a breathalyzer test. Staff member refused to be tested and left the facility. A water bottle tumbler was then found on her neighborhood that had pink liquid in it that smelled strongly of alcohol. By leaving without submitting to a breathalyzer, CNA Q violated Bethany policy and was terminated on the afternoon of 4/29/24. - "Interview with CNA/Med Aide N: CMA N was assisting CNA Q with cares with the above resident and stated that CNA Q was discussing problems with her boyfriend with the resident. At that time CMA N said she was acting weird and was thinking hard about what she was going to say before she spoke. CNA Q then asked CMA N	F 610		

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F 610	Continued From page 32	F 610		

for help assisting the above listed resident. During cares for the above listed resident CNA N said CAN Q smelled of alcohol and that CNA Q was having hard time completing the cares for the resident. CMA N stated he never saw her drinking any liquids that night and did not see CNA Q drinking from the cup that was later found to have alcohol in it. CMA N told the nurse on duty who call the DON B. CMA N said the nurse on duty told CNA Q she would need to be breathalyzed at which time CNA Q left the facility."

- "Interview with licensed practical nurse (LPN) R: LPN r stated that both her and CAN Q arrived to work at 6:00 p.m. at which time LPN R started passing pills on Maple Valley. LPN R stated she got to Cottonwood Court around 8:15 p.m. She saw CNA Q in the dish room talking on her phone and that CNA Q ran into the door frame of the dish room when she came back out. CMA N approached LPN R at about 9:00 p.m. and said that CNA Q smelled like alcohol. LPN R texted DON B. During this time, LPN R stated that CNA Q would disappear off the unit for extended periods of time and they would find her in random resident rooms. LPN also stated that CNA Q was very anxious and having a hard time speaking during the shift. At 9:45 p.m. LPN R informed CNA Q that the police were on their way and that she would be subjected to a mandatory breathalyzer to which CNA Q seemed nervous and said that is suspicious. LPN R went to go assess a resident and when she came back CNA Q was gone. LPN R went to the front entrance of the facility and saw CNA Q with the police. After LPN R returned to the neighborhood, she found the green tumbler at which point she opened the container and smelled it and it smelled strongly of alcohol. CNA Q refused a breathalyzer from the

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

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F 610	Continued From page 33	F 610		

police and left the facility. Police informed Administrator A and DON B that they could not pursue any charges against her as they had no evidence that a crime had been committed. CNA Q was terminated effective 4/29/24."
*"Substantiation and Action: Was abuse/neglect allegations substantiated: No, why or why not? Unable to completely substantiate but evidence presented made it clear that CNA Q needed to be terminated."
- "If a patient/resident was suspected of abuse/neglect, was it a willful act? Yes."
- "Action taken by the facility; Personnel terminated."

11. Review of Bethany Homes/Meadows/Foundation 2024 Employee handbook revealed:
"*Drug Testing on page 33":
-" Bethany has adopted screening and testing practices to identify employees who use illegal drugs on or off the job, and to identify employees under the influence of alcohol on the job. Refusal to submit to drug or alcohol testing being conducted by the facility will be considered a positive test. Such refusal may lead to disciplinary action, up to and including immediate termination."
*" Purpose: In compliance with the Drug-Free Workplace Act of 1988, Bethany has a longstanding commitment to provide a safe, quality-oriented, and productive work environment consistent with the standards of the community in which Bethany operates. Alcohol and drug abuse poses a threat to the health and safety of Bethany employees, residents, family, and guests. For these reasons, Bethany is committed to the elimination of drug and alcohol use and abuse in the workplace."

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BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

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F 610	Continued From page 34 *"Work Rules:" - "1. Whenever employees are working, are present on Bethany premises or are conducting company-related work offsite, that are prohibited from: - "b. Being under the influence of alcohol, or an illegal drug as define in this policy." - "c. Possessing or consuming alcohol." *" Page 35 Reasonable suspicion:" - "Employees are subject to testing based on (but not limited to) observations by the supervision of apparent workplace use, possession, or impairment. HR [human resources], the supervisor or Administration are to be consulted before sending an employee for testing. Under no circumstances will the employee be allowed to drive himself or herself to the testing facility. A member of supervision/management must escort the employee or arrange for a safe driver, the supervisor/ manager will make arrangements for the employee to be transported home. The expense of this arrangement will be the responsibility of the employee." *" Follow-up:" - "Employees who have tested positive, or otherwise violate this policy, are subject to discipline, up to and including discharge from employment. At management discretion depending on the circumstances and the employee's work history/record, Bethany may offer an employee who violates this policy or test positive one time the opportunity to return to work on a last-chance basis pursuant to mutually agreeable terms, which could include follow-up drug testing at times and frequency determined by Bethany for a minimum of one year. If the employee either does no complete the rehabilitation program ort tests positive after completing the rehabilitation program, the	F 610		

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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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) COMPLETION DATE
F 610	Continued From page 35 employee will be subject to immediate discharge from employment." *Consequences": - "Employees who refuse to cooperate in required test or who use, possess, buy, sell manufacture or dispense an illegal drug in violation of this policy will be terminated. If the employee refuses to be tested, yet the company believe he or she is impaired, under no circumstances will the employee be allowed to drive himself or herself home. Refusal to cooperate will result in a call to the police." - "Page 36, The first time an employee tests positive for alcohol or illegal drug use under this policy, the result will be discipline up to and including discharge." - "Employees will be paid for time spent in alcohol or drug testing and then suspended without pay pending the results of the drug or alcohol test." *Page 58, Discipline Procedures: - "3. Suspension: Suspension is a form of discipline normally reserved for severe infractions of rules, standards, or for excessive violations for which the employee has already received a written warning and the employee has made insufficient effort to improve performance or behavior. However, an employee can be placed on paid or unpaid suspension for disciplinary reasons, for example; excessive absenteeism, medication errors, or an incident requiring investigation such as, abuse, or the results of drug testing.' - "4. Termination: Bethany may accelerate or omit any of the steps mentioned above."	F 610		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641	On 12/02/2024, DON, or designee, will assess resident 23 and 32 to ensure their need for a trunk belt is accurate and coded correctly and that the trunk belt is included on the care plan. On 12/02/2024, DON, or designee, will assess	12/10/2024

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 641	Continued From page 36 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the Centers for Medicaid and Medicare (CMS) Resident Assessment Instrument (RAI) Manual review, the provider failed to ensure the Minimum Data Set (MDS) assessments were coded accurately for two of two residents (23 and 32) who had a seat belt in their wheelchairs. Findings include: 1.Observation and interview on 11/5/24 at 2:04 p.m. with resident 23 revealed: *She was in her room in an electric wheel chair and had a seat belt on. *She stated she could do most things for herself from her waist up. *She would do crafts and sew in her room and would help with seasonal decorating of the facility. Review of resident 23's electronic medical record revealed (EMR): *Her Brief Interview of Mental Status (BIMS) assessment dated 10/10/24 had a score of fifteen which indicated her cognition was intact. *Her MDS dated 10/10/24 indicated: -Trunk restraint was coded as not used in the chair or the bed. -Other was coded as "Used daily." -An edit note, "Resident uses a seat belt on her electric wheelchair. She utilizes this per her choice. She ss able to don [put on] after set up, and doff [remove] this independently. This is reassessed quarterly." *She had a restraint assessment completed on 10/21/24 for the use of the seat belt on her power	F 641	all other residents with trunk belts to ensure that their need for a trunk belt is accurate and coded correctly and included on the residents care plan. IDT, in collaboration with the Medical Director, reviewed and revised, as necessary, the policies and procedures relating to resident restraints and proper MDS coding for those restraints on 11/29/2024. All staff will be edcuated via in-service on 12/04/2024 regarding the policies and procedures relating to resident restraints. Beginning 12/02/2024, DON, or designee, will audit that residents with trunk belts have the necessary assessment, that the belts are coded correctly, and that they are reflected on the care plan 2x a week for 3 months. DON, or designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 641	Continued From page 37 wheelchair that indicated she could release it herself and felt safer with this on. *Her care plan dated 2/1/22 indicated she requested the seat belt for safety and could apply it and remove it herself. *That care plan also included "Perform restraint assessments quarterly and as needed due to the use of my seatbelt in my electronic wheelchair." 2. Observation and interview on 11/05/24 at 2:26 p.m. with resident 32 revealed she: *Had limited movement of the right arm and hand. *Was seated in a wheelchair with a forward-leaning posture. -The wheelchair had a seat belt that was not fastened. --The seat belt straps hung in front of the brakes on each side of the wheelchair. *Stated she had several falls that led to her admission to the facility, but "I've been more careful and haven't fallen recently." *Stated she wasn't sure what the seat belt was for and did not know if she could remove it on her own because she was not wearing it. *Was easily distracted and changed the subject frequently. Observation and interview on 11/08/24 at 9:15 a.m. with resident 32 revealed she: *Was seated in her wheelchair and the seat belt straps hung in front of the brakes on each side of the wheelchair. *Was easily distracted and unable to demonstrate that she could put on or remove the seatbelt. *Stated, "I don't know what is going on today." Review of resident 32's EMR revealed: *She was admitted on 5/5/23.	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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) COMPLETION DATE
F 641	Continued From page 38	F 641		

*Her 10/31/24 Brief Interview for Mental Status (BIMS) assessment score was 9, which indicated she was moderately cognitively impaired.
*Her care plan included an intervention initiated on 2/5/24, "OT [occupational therapy] has put a seat belt on my wheelchair to help with positioning. I am able to put it on and remove it on my own."
*Her care plan included an intervention initiated on 4/8/24, "I have dycem [a non slip mat] in my wheelchair and have received verbal education on the importance of using the seatbelt in my wheelchair that OT previously provided. I am able to apply and remove this myself."
*An 11/4/24 "Restraint Assessment" that indicated:
-The "Type of restraint considered for use: seat belt."
-"Reason restraint is considered: (describe) wheelchair positioning."
-"During what time of day would it be used? When resident is up in wheelchair."
-"How long each day? Anytime in w/c [wheelchair]."
-"What is the resident/family wishes or attitude related to restraint use? Family and resident ok with safety belt."

Review of resident 32's 10/31/24 quarterly MDS assessment, section P (Restraints and Alarms) revealed:
*Trunk restraint was coded as not used in the chair or the bed.
*Other was coded as "Used less than daily."
*An edit note, "resident has a seatbelt that she is able to remove herself. However, she rarely uses it."

3. Interview on 11/08/24 at 10:34 a.m. with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 39 director of nursing (DON) B revealed: *She confirmed two residents in the facility used seat belts. *Resident 23 had a seatbelt as a safety device that she used daily. *Resident 32 had a seat belt for "safety, that she rarely used." *She stated, "They are not being used as a restraint." *She assisted with the completion of the MDS assessments. -She confirmed the seatbelts were coded on the MDS as restraints. Review of the October 2023 CMS RAI Version 3.0 Manual Section P, Page P-6 revealed: *"Trunk restraints include any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove such as, but not limited to, vest or waist restraints or belts used in a wheelchair that either restricts freedom of movement or access to their body." Review of the providers' revised 1/1/24 Physical Restraint Policy and Procedure to be Least Restrictive policy revealed: *"Physical restraints are any method or physical or mechanical device, material, or equipment attached to the resident's body that the individual cannot remove easily, which restricts freedom of movement for normal access to one's body; this includes... wheelchair belts... that cannot be released easily by their resident..."	F 641		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing	F 801	Administrator reviewed and revised, as necessary, the Job Descriptions with Dietary Director E, CRD H, and the maintenance director on 11/27/2024. Administrator reviewed the conctractural	12/10/2024

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F 801	Continued From page 40 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements	F 801	agreement with CRD consultant on 11/27/2024 to ensure there is language about the CRD's role in leading the food and nutritional services department and provides education for training of dietary staff. Dietary Director E, CRD H, Maintenance Director, and, and all staff were educated on each of these roles and their responsibilities on 12/04/2024. Administrator, Dietary Manager, and RD, in collaboration with the Medical Director, reviewed the plan prepared for the removal of the immediacy on 11/27/2024. On 11/07/2024, the Environmental Services Director calibrated the dish machine on all neighborhoods impacting residents 1, 3, 14, 17, 18, 21, 23, 24, 25, 26, 27, 31, 34, 35, 36, 38, 39, 40, 41, 42, 44, 46, 47, 48, 49, and 50 to ensure they reached the proper temperature on all neighborhoods. IDT, in collaboration with the Medical Director, reviewed and revised the policies and procedures related to dish machine temperature logs and the sanitation of dish machines on 11/07/2024. All staff responsible for using the neighborhood dish machines were educated on the policies and procedures related to the dish machine temperature log and the sanitation of dishes/ dish machines by 11/15/2024. CMA J, Dietary Aide S, Cook T, and all staff responsible for using the neighborhood dish machines were educated that if dish machine temperatures do not reach between 150 and 160 degrees F during wash cycle and 180 degrees F during sanitation cycle they must inform the Environmental Services Director and the machines must not be used. This education was completed by 11/15/2024. Beginning 11/07/2024, the Dietary Director, or designee, will audit the dish machine temperature logs to ensure they are being completed. Audits will be daily for four weeks and 2x per week for two more months.	

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F 801	Continued From page 41 no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by:	F 801	Beginning 12/09/2024, the Dietary Director, or designee, will conduct random dishwasher temperature audits to ensure the dishwasher is reaching the required temperatures during the wash and sanitizing cycles 2x per week for 3 months. CRD will conduct the same audit 1x per week for 3 months during her weekly visits to the facility. The Dietary Director or Designee will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting. IDT, in collaboration with the Medical Director, reviewed and revised the policies and proceudres, as necessary, relating to sanitizing bucket preparation and documentation on 11/27/2024. A sanitizer solution log was implemented on 11/06/2024 to ensure staff are testing the santizier solution and that it falls within the proper parameters. CMA J, Dietary Aide S, Cook T, and all staff will be educated via in-service on 12/04/2024 on the policies and procedures related to sanitizer bucket preparation and documentation. Beginning 12/02/2024, the Dietary Director, or designee, will audit the completion of the sanitizer bucket preparation log daily for 4 weeks and then 2x per week for two more months. Beginning 12/09/2024, the Dietary Director, or designee, will conductaudits on the sanitizer solution to ensure it is falling within the proper parameters 2x per week for 3 months. CRD will conduct the same audit 1x per week for 3 months during her weekly visits to the facility. The Dietary Director, or designee, will present the findings of the audit to the QAPI commitee for reivew and recommendation at their quarterly meeting. Administrator, DON, Dietary Manager and RD,	

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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F 801	Continued From page 42 Based on observation, interview, record review, and job description review the provider failed to ensure the dietitian and dietary director carried out the functions of the food and nutrition services department to ensure the development and implementation of policies and procedures regarding appropriate cleaning, sanitization, and record-keeping were completed in the food and nutrition departments that included the main kitchen and four kitchenettes. Failure to ensure this oversight of the food and nutrition services department increased the potential risk of foodborne illnesses for the entire resident population who received meals that were prepared in the main kitchen and served from the kitchenettes. Findings Include: 1. Refer to F812 2. Interview on 11/08/24 at 12:36 p.m. with dietary director (DD) E revealed: *She was a certified dietary manager. *She had been in her current position for two months. *She had not been aware of the regulations in nursing home kitchens. -Her previous position was not in a nursing home. *She had not seen the policies requested by the survey team until that week. *Consultant registered dietitian (CRD) H visited once a week on Thursdays. -Those visits were not recorded. --CRD H documented in residents' medical records. ---She confirmed that CRD "checked-in" with her during those visits. *There were no food service related audits being conducted that she was aware of. *No food service related audits had been	F 801	in collaboration with the medical director, reviewed and revised the policies and procedures about appropriate handling of ready to serve food on 11/27/2024. Dietary Aide S, Cook T, CMA J, CES D, Maintenance Staff U, and all staff will be educated on 12/04/2024 regarding the policies and procedures relating to handling of ready to servie food. The policies regarding ready to serve food were sent to contracted hospice agencies on 12/02/2024 with request for signatures from all of their direct care staff acknowledging the education had been reveived to be completed by 12/10/2024 Beginning 12/02/2024, Dietary Director or designee will audit that ready to eat foods are being delivered and administered appropriately 2x a week for 3 months. Dietary Director, or Designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting. IDT, in collaboration with the Medical Director, reviewed and revised the daily kitchenette cleaning duties form on 11/27/2024. Dietary Aide S, Cook T, CMA J, CES D, Maintenance Staff U, and all staff will be educated via in-service on 12/04/2024 regarding the policies and procedures relating to daily kitchenette cleaning duties. Beginning 12/09/2024, DON or designee, will audit that the kitchenette cleaning checklists are being completed daily for 4 weeks and then 2x per week for 2 more months. Beginning 12/09/2024, DON, or designee, will conduct random audits of the kitchenette areas to ensure they are clean that that the duties outlined in the cleaning checklists are being completed 2x per week for 3 months. DON, or designee, will present the findings of the audit to the QAPI committee for review	

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F 801	Continued From page 43 completed since she started that she was aware of. Review of the provider's undated Dietary Director Position Description revealed: *"The Dietary Director is responsible for coordinating the food service program to provide nutrition and variety within a budget. Consult with residents, staff, and dietician to ensure that therapeutic diet needs of residents are met. *The supervisor was listed as the administrator. *Essential job responsibilities included: -"Consult with dietician as needed and directed according to state regulation and resident need." -"Maintain a clean, orderly and safe kitchen environment." -"Develop and implement policies and procedures in the food service program that are in compliance with food service regulations." -"Adhere to and carry out all policies and procedures." Review of the providers 7/17/23 Contract for Registered Dietitian Services revealed: *"The purpose of this Agreement is to arrange for Registered Dietitian (RD) consultation and management materials for the above named facility." -The facility listed above was a sister facility located in Sioux Falls. *Responsibilities of the Consultant Dietitian included: -"Consults with Administration regarding planning of Food & Nutrition Service department policy Development, establishing goals and priorities in integrating Food & Nutrition Services into the Facility's total program. -"Supports the Food & Nutrition Services Supervisor in maintaining department standards	F 801	and recommendation.	

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F 801	Continued From page 44 and all applicable regulations related to food procurement, receiving, storage, preparation, and service." -"Assists in evaluating, developing and/or writing Food Service Policies and Procedures." -"The Facility and [contract company name] shall mutually, on a periodic basis, review and approve the Food & Nutrition Services policies and establish future goals. -"[Contract company name] may make recommendations to ensure quality food service and/or to comply with rules and regulations of the Federal or State governments. The Facility, however, is responsible for approving, implementing and maintaining recommendations made by [contract company name]." *The contract was not signed by the current facility administrator. Review of the provider's undated Maintenance Director Position Description revealed: *"The Maintenance Director is responsible to maintain building and grounds." *The supervisor was listed as the administrator. *Essential job responsibilities included: -"Carry out the preventative maintenance program." -"Repair or replace damaged or broken fixtures or equipment." -"Carry out other tasks as assigned by supervisor." *Knowledge Expectations included: "Function and operation of kitchen appliances, office equipment maintenance equipment and grounds equipment, with ability to do minor repairs." *The position description review did not reveal oversight of the kitchenettes or monitoring of the kitchenette dishwasher temperatures.	F 801		

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F 812	Continued From page 45	F 812		
F 812 SS=K	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Ensure that staff were able to verify the chemical sanitation level required to clean the main kitchen surfaces used for the preparation of residents' food. Failure to ensure that increased the potential risk of foodborne illnesses for the entire resident population who received meals prepared in the main kitchen. *Maintain the dishwasher sanitation rinse cycle temperature at a minimum of 180 degrees Fahrenheit per the manufacturer's manual for two of four kitchenette dishwashers. Failure to ensure that increased the potential risk of foodborne illnesses for 27 of 27 residents (1, 3, 14, 17, 18,	F 812	Administrator reviewed and revised, as necessary, the Job Descriptions with Dietary Director E, CRD H, and the Maintenance Director on 11/27/2024. Administrator reviewed the contractual agreement with CRD contultant on 11/27/2024 to ensure there is language about the CRD's role in leading the food and nutritional services department and provides education for training of dietary staff. Dietary Director E, CRD H, Maintenance Director, and all staff were educated on each of these roles and their responsibilities on 12/04/2024. Administrator, Dietary Director, and RD, in collaboration with the Medical Director, reviewered the plan prepared for the removal of the immediacy on 11/27/2024. On 11/07/2024, the Environmental Services Director calibrated the dish machines on all neighborhoods impacting residents 1, 3, 14, 17, 18, 21, 23, 24, 25, 26, 27, 31, 34, 35, 36, 38, 39, 40, 41, 42, 44, 46, 47, 48, 49, and 50 to ensure they reached the proper temperature on all neighborhoods. IDT, in collaboration with the Medical Director, reviewed and revised the policies and procedures, related to dish machine temperature logs and the santitation of dish machines on 11/07/2024. All staff responsbile for using the neighborhood dish machines were educated on the policies and procedures related to the dish machine temperature log and the sanitation of dishes/ dish machines by 11/15/2024. CMA J, Dietary Aide S, Cook T, and all staff responsible for using the neighborhood dish machines were educated that if dish machine temperatures do not reach at least between 150 and 165 degrees F during wash cylce and at least 180 degrees F during sanitation cycle they must inform the Environmental Services	12/10/2024

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F 812	Continued From page 46 21, 23, 24, 25, 26, 27, 31, 34, 35, 36, 38, 39, 40, 41, 42, 44, 46, 47, 48, 49, 50, and 52) who received meals on dishware cleaned in those two kitchenettes. Findings include: 1. Observation and interview on 11/5/24 at 11:41 a.m. during the initial tour of the main kitchen revealed: *There was a metal cart with visibly soiled dishes in the entryway to the kitchen located between the door and the dishwasher. *The floor below the sink was wet. *A pan marked "beef for stroganoff" on the counter. *Dietary director (DD) E stated she started in her position two months ago. -She indicated there had been a "huge staff turnover." *DD E stated that the residents' food prepared for lunch had already been delivered to the neighborhoods. -Lunch was served starting at 11:30 a.m. *The beverage dispensing machine was taken apart and cleaned. *A red "sani-bucket" was on a metal cart that contained liquid and a cloth. *The sanitizer strip test kit was labeled "expired September 2024.". *The "Diversey" chlorine test strips were labeled "exp May 15, 2024." *A dishwasher wash and rinse log on the wall had recorded temperatures for breakfast, lunch, and dinner on 11/2/24. -No dishwasher wash or rinse temperatures had been recorded on 11/1/24, 11/3/24, 11/4/24 or 11/5/24. Interview on 11/5/24 at 12:11 p.m. with dietary	F 812	Director and the machines should not be used. This education was completed by 11/15/2024. Beginning 11/07/2024, the Dietary Director, or designee, will audit the dish machine temperature logs to ensure they are being completed. Audits will be daily for 4 weeks and then 2x per week for two more months. Beginning 12/09/2024, the Dietary Director, or designee, will conduct random dishwasher temperature audits to ensure the dishwasher is reaching the required temperatures during wash and sanitizing cylces 2x per week for 3 months. CRD will conduct the same audit 1x per week for 3 months during her weekly visit to the facility. The Dietary Director, or designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting. IDT, in collaboration with the Medical Director, reviewed and revised the policies and procedures, as necessary, relating to sanitizing bucket preparation and documentation on 11/27/2024. A sanitizer solution log was implemented on 11/06/2024 to ensure staff are testing the sanitizer solution and that it falls within the proper parameters. CMA J, Dietary Aide S, Cook T, and all staff will be educated via in-service on 12/04/2024 on the policies and procedures related to sanitizer bucket preparation and documentation. Beginning 12/02/2024, the Dietary Director, or desginee will audit the completion of the sanitizer bucket preparation log daily for 4 weeks and then 2x per week for two more months. Beginning 12/09/2024, the Dietary Director, or designee, will conduct audits on the sanitizer solution to ensure it is falling within the proper parameters 2x per week for 3 months. CRD will conduct the same audit 1x per week for 3	

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F 812	Continued From page 47 aide S in the main kitchen revealed: *The sanitizer test strips were used for testing the contents in the 3-compartment wash sink and the sanitizer buckets. -They were the only test strips in the kitchen. *There was no log documenting when the strips had been used. *All dishes used in the main kitchen were put through the dishwasher. -It was a high-temperature dishwasher. *There was a log to record the dishwasher temperatures for the washing of the dishes used with each meal service. -The dishes for lunch had not been washed yet that day. Observation and interview on 11/6/24 at 10:45 a.m. in the main kitchen with cook T revealed: *She used a cloth from the red "sani-bucket" to wipe the counter where she had prepared fried food. *She rinsed the cloth in the red bucket and continued to wipe the surfaces of the items on the counter with that cloth. *She stated the bucket was "filled every two hours or more often when dirty." *She stated she "keeps track" of her bucket and changes it "at least every 2 hours but usually more often" when she used it. *She confirmed there was no log or sticker on the bucket that indicated when it had been last changed or tested. *The sanitizer in the bucket was a chemical solution filled from the hose at the 3-part sink. *She stated, "They [sani-buckets] are tested every so often." -She was unsure how often the sanitizer was tested. -She stated she did not do the testing.	F 812	months during her weekly visit to the facility. Dietary Director, or designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting. Administrator, DON, Dietary Director, and RD, in collaboration with the Medical Director, reviewed and revised the policies and procedures related to appropriate handling of ready to servie food on 11/27/2024. Dietary Aide S, Cook T, CMA J, CES D, Maintenance Staff U, and all staff will be educated via in-service on 12/04/2024 regarding the policies and procedures relating to handling of ready to servie food. The policies regarding ready to serve food were sent to contracted hospice agencies on 12/02/2024 with request for signatures from all of their direct care staff acknowledging the edcuation had been received to be completed by 12/10/2024. Beginning 12/02/2024, Dietary Director, or designee will audit that ready to eat foods are being delivered and administered appropriately 2x per week for 3 months. Dietary Director, or Designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting. IDT, in collaboration with the Medical Director, reviewed and revised the daily kitchenette cleaning duties form on 11/27/2024. Dietary Aide S, Cook T, CMA J, CES D, Maintenance Staff U, and all staff will be educated via in-service on 12/04/2024 regarding the policies and procedures relating to daily kitchenette cleaning duties. Beginning 12/09/2024, DON or designee, will audit that the kitchenette cleaning checklists are being completed daily for 4 weeks and then 2x per week for 2 more months.	

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BETHANY HOME - BRANDON	3012 E ASPEN BLVD BRANDON, SD 57005

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F 812	Continued From page 48 *She confirmed that it was not tested each time the bucket was filled to ensure proper sanitization. Observation and interview at 11/6/24 at 10:50 a.m. with DD E in the main kitchen revealed she: *Confirmed they did not have a system to test the solution in the "sani-buckets" to ensure the sanitizer was at the appropriate level or a method to document the testing results. *Confirmed the chlorine test strips were expired. -She stated, "But that's ok because we don't use them anyway." *Stated, "They [staff] weren't doing it [using the chlorine test strips] when I started." *Was unsure what the facility policy was but stated "I will find out." *Confirmed that the solution was "J-512 Sanitizer" and stated it was a "preset system so we do not have to test." *Confirmed the dishwasher was a high-temperature dishwasher. *A dishwasher log was posted on the wall. -The dishwasher log had rinse temperatures recorded over 180 degrees for 11/5/24 and 11/6/24. Observation and interview on 11/6/24 at 11:22 a.m. in the Plumb Creek kitchenette with DD E revealed she: *Transported the food from the main kitchen to the Plumb Creek kitchenette. *Obtained dishes from the cabinet in that kitchenette. *Confirmed that those dishes were washed and sanitized in the dishwasher in the kitchenette. -Confirmed each neighborhood washed its own plates, cups, bowls, and utensils that were used for serving the residents food items.	F 812	Beginning 12/09/2024, DON, or designee, will perform random audits of the kitchenette areas to ensure they are clean and that the duties outlined in the cleaning checklists are being completed 2x per week for 3 months. DON, or designee, will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 49	F 812		

Observation and interview on 11/6/24 at 12:09 p.m. in the Plumb Creek dish room with CMA J revealed:
*The nursing staff was responsible for washing and sanitizing the dishes in each neighborhood.
*She "pre-washed" the dishes in the sink and loaded them into the dishwasher.
*She ran the dishwasher cycle.
-The wash temperature reached 165 degrees and the rinse temperature reached 183 degrees.
*She stated she did not log or record any dishwasher wash or rinse temperatures.
*She stated, "If that's [logging of temperatures] done it would be maintenance."
*She confirmed there was no dishwasher log located in the kitchenette.

Interview on 11/6/24 at 3:37 p.m. with Administrator (Admin) A revealed:
*There were no cleaning logs for the kitchen or kitchenettes.
*He expected nursing staff to wash the dishes, to mop the floor, and to keep the area clean.
*The neighborhood kitchenettes had not used the "sani-bucket."
-The cleaner on the kitchenette was the "Q 3 disinfectant spray."
*He confirmed that in the main kitchen, they used the "sani-bucket."
*He confirmed that "they should be testing the PPM [parts per million of the sanitizer solution] for the sanitizer buckets" to ensure the sanitizer was at an appropriate level.
-He confirmed there was no record that the sanitizer had been tested.
*He was not aware that the sanitizer test strips were expired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 50 Interview on 11/6/24 at 4:30 p.m. with Admin A revealed: *The provider did not have a "Dishwasher/Sanitation" policy. *He stated we "go by the manufacturer's book." *The provider did not have a "Household/neighborhood kitchenette cleaning" policy or logs. *The provider did not have a "Kitchen equipment sanitizing/cleaning" policy or logs. *Maintenance would have had kitchenette dishwasher temperature logs because they oversaw the kitchenette dishwashers. Interview and review of kitchenette dishwasher logs and dishwasher manufacturer specification on 11/06/24 at 4:31 p.m. with campus environmental service director (CESD) D revealed: *He provided a copy of the Hobart Model LXIH-4 LHi Dishmachine specifications which included the following: -"RINSE AND SANITATION: LXIH: Sanitation is accomplished by means of a built-in booster heater designated to raise temperature of water to a minimum of 180 degrees Fahrenheit from an incoming water temperature of 110 degrees Fahrenheit." *This was the information used when determining the correct dishwasher temperatures. *Neighborhood kitchenette dishwasher temperature logs were completed and kept by maintenance. -Dishwasher temperatures were monitored and logged on each of the four neighborhoods "about once every three weeks" by maintenance. -He was not aware if any other staff monitored those dishwasher temperatures. *He kept the recorded temperatures in a	F 812		

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 51	F 812		

notebook.
*The dishwasher temperatures were checked and logged on 8/5/24, 8/19/24, 8/28/24, 9/15/24, 10/7/24, and 10/28/24.
-All of those "wash" temperatures were recorded between 154-164 degrees Fahrenheit.
-All of those "rinse" temperatures were recorded between 180-186 degrees Fahrenheit.

Interview on 11/7/24 at 7:45 a.m. with Admin A revealed:
*He provided the survey team with a "Kitchen Sanitation Policy" dated "11/2024."
-He confirmed this policy included the main kitchen and the kitchenettes.
*He provided the survey team with a "Sanitizer Preparation Policy" dated "01/2024."
*He confirmed they did not have a separate "dishwashing policy" and referred to the manufacturer information previously provided.
*He stated the dietitian would be at the facility "today" 11/7/24.

Observation and interview on 11/7/24 at 8:12 a.m. with consulting registered dietitian (CRD) H in the main kitchen revealed she:
*Visited the facility once a week on Thursdays.
*Documented her visits with individual residents in their charts.
*"Checks-in" with DD E when she visited.
-She did not document those "check-ins."
-They also communicated through email.
*Was not conducting any current audits in the kitchen.
-Was unable to recall if she had completed any audits recently, "I would have to check my email."
-Confirmed there were no written audits completed.
*Stated, "There is a cleaning schedule" for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 52 kitchen. -Stated she would provide a copy of that cleaning schedule to the survey team. --A cleaning schedule was not provided by the end of the survey. *Was not familiar with the procedures of sanitizing in the kitchen and agreed that we should include DD E in the interview. Continued observation and interview on 11/7/24 at 8:18 a.m. with CRD H and DD E in the main kitchen revealed: *DD E demonstrated the use of the "sani-bucket." -She confirmed the new test strips were not expired. -There was a new log sheet for recording when the sanitizer solution was filled or tested. -She confirmed that the sanitization level in the "sani-bucket" was 200 PPM. -That had been documented on the log in the kitchen when it had been filled that morning. *DD E confirmed the main kitchen dishwasher temperatures were logged with each meal service three times a day. *DD E was unsure if there was a policy on the frequency of checking the dishwasher temperatures. *DD E confirmed that the dishes used by the residents including plates, bowls, cups, and utensils were washed and sanitized in each of the four neighborhoods. *DD E was unsure how frequently the neighborhood dishwasher wash and rinse temperatures should have been monitored. *CRD H stated she expected it would have been "the same frequency as the main kitchen." *DD E stated that maintenance oversees the neighborhood kitchenettes, and any dishwasher temperature logs could be requested from that	F 812		

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 53 department. -CRD H and DD E were not aware of what frequency maintenance checked the kitchenette dishwasher temperatures. *When asked how they could ensure that dishes were sanitized in the neighborhood kitchenettes, DD E stated, "I couldn't." *CRD H and DD E were not familiar with the procedures of sanitizing dishes in the neighborhood kitchenettes and agreed that we should include maintenance in the interview. Observation and interview on 11/7/24 at 8:39 a.m. in the Willow Wood Way kitchenette with CRD H, DD E, CESD D, and maintenance staff U revealed: *A sign on the dishwasher indicated "This is a sanitizer. Not a dishwasher." -Maintenance staff U confirmed that the machine is both a dishwasher and a sanitizer and the sign was inaccurate. -She stated that the dishes are prewashed before putting them in the machine to reduce the food particles in the machines. *Maintenance staff was responsible for overseeing the dishwashers for proper functioning in the kitchenettes. *The dishwasher had an E7 code displayed. -Maintenance staff U stated the code indicated the dishwasher was out of soap. --She changed the soap and reset the machine. *Maintenance staff U stated she checked the dishwashers "Every day I am here." -She did not keep a log or record those checks. -She stated she looked at the temperature on the digital display of the dishwasher and "as long as it is 150 or above it's good." -When the temperature was below 150 degrees Fahrenheit, she would reset the machine.	F 812		

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	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 54 -There was no need to run the dishwasher through a cycle to check the rinse temperature during those checks, "because it's always hot enough." *Maintenance staff U ran the dishwasher. -On the first cycle the wash temperature reached 164 degrees Fahrenheit, and the rinse temperature reached 180 degrees Fahrenheit. *Maintenance staff U stated she expected staff to alert her "right away" if there were any problems with the dishwashers. Observation and interview on 11/7/24 at 8:52 a.m. in the Cottonwood Court kitchenette with CRD H, DD E, CESD D, and maintenance staff U revealed: *Maintenance staff U ran the dishwasher. *On the first cycle the wash temperature reached 165 degrees Fahrenheit, and the rinse temperature reached 177 degrees Fahrenheit. *A sign in the kitchenette indicated that plates, bowls, and cups were to be sanitized twice and utensils were to be sanitized three times. *On the second cycle the wash temperature reached 165 degrees Fahrenheit, and the rinse temperature reached 177 degrees Fahrenheit. *On the third cycle the wash temperature reached 162 degrees Fahrenheit, and the rinse temperature reached 174 degrees Fahrenheit. -Those temperatures were confirmed by maintenance staff U, CRD H, DD E, and CESD D. *A copy of the posted sign was requested in the absence of a policy and was not provided by the end of the survey. *CESD D confirmed the last time the kitchenette dishwasher temperatures were checked and recorded was on 10/28/2024.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 55 Observation and interview on 11/7/24 at 8:58 a.m. in the Maple Valley kitchenette with CRD H, DD E, CESD D, and maintenance staff U revealed: *Maintenance staff U ran the dishwasher. *On the first cycle the wash temperature reached 160 degrees Fahrenheit, and the rinse temperature reached 179 degrees Fahrenheit. *On the second cycle the wash temperature reached 166 degrees Fahrenheit, and the rinse temperature reached 179 degrees Fahrenheit. *On the third cycle the wash temperature reached 167 degrees Fahrenheit, and the rinse temperature reached 177 degrees Fahrenheit. -Those temperatures were confirmed by maintenance staff U. Observation on 11/7/24 at 9:15 a.m. of maintenance U revealed she walked from Cottonwood Court through the common area outside of the conference room carrying what appeared to be a cordless drill/screwdriver. Interview on 11/7/24 at approximately 10:00 a.m. with Admin A regarding the dishwasher temperatures revealed: *He requested that the surveyor return to recheck the temperatures of the dishwasher. *He stated the dishwashers had been "calibrated" and had temped them and they were at the correct temperature. Interview on 11/7/24 at 9:45 a.m. with CRD H revealed: *She provided the survey team with a "2013 Becky Dorner & Associates Sanitation of Dishes/Dish Machine" policy. -This policy had not been provided earlier. *She stated that this was the regulation that they	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 56	F 812		

followed regarding dishwasher temperatures.

Review of the 2013 Becky Dorner & Associates Sanitation of Dishes/Dish Machine policy revealed:
*"High Temperature Dishwasher Wash Temperature 150-160 degrees Fahrenheit, Final Rinse Temperature or Sanitization 180 degrees Fahrenheit."

Notice:
On 11/7/24 at 8:58 a.m., immediate jeopardy was identified related to failure to maintain the manufacturer's specification for the dishwashers' rinse cycle temperatures of a minimum of 180 degrees Fahrenheit at F812.
Notice of immediate jeopardy was given verbally and in writing on 11/7/24 at 11:55 a.m. to Admin A and director of nursing B of the immediate jeopardy related to failure to maintain the manufacturer's specification for dishwasher rinse cycle temperatures of a minimum of 180 degrees Fahrenheit at F812. They were asked for an immediate removal plan. The current resident census was 52.
Interview on 11/7/24 at 1:18 p.m. with Admin A and the survey team coordinator revealed:
*He requested to speak with the survey team coordinator.
*He stated he felt like this was "certainly tag worthy but from an immediate jeopardy perspective I feel like that is incredibly out of proportion."
*He stated, "Within five minutes of that temperature being off, it was corrected."
*He stated, "I would completely understand a tag associated with that, and for corrective action and for not documenting it."
*He stated he understood the deficiency was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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) COMPLETION DATE

F 812 Continued From page 57 F 812

warranted but was concerned with the repercussions from an IJ severity deficiency.
*The survey team coordinator asked about the IJ removal plan and stated the team needed to review the provider's IJ removal plan to continue with the process.

On 11/7/24:
*At 1:31 p.m. the removal was received.
*At 2:17 p.m. the removal was accepted.

On 11/7/24:
*At 4:06 p.m. while on-site the survey team verified the immediacy was removed.

Plan:
"Survey 11/07/2024 Removal Plan
After evaluation and meeting with the survey team, the recipients who could have suffered from this situation are the residents at Bethany Home Brandon on Maple Valley and Cottonwood Court as those were the neighborhoods that had temperature readings below 180 degrees.

Neighborhood Dish Machine POC [plan of correction]:

On 11/07/2024, the Environmental Services Director calibrated the dish machines on all neighborhoods to increase the temperature of the rinse cycle. Both dish machines on Cottonwood Court and Maple Valley did reach the required temperature of 180 degrees before recalibration. All rinse cycles reached at least 180 degrees F [Fahrenheit] after changes made.

Beginning 11/07/2024, a dish machine temperature log was implemented on all neighborhood dish machines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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

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F 812	Continued From page 58 IDT [interdisciplinary team] reviewed and revised the policy and procedures related to dish machine temperature logs and the sanitation of dishes/dish machines on 11/07/2024. Beginning 11/07/2024, all staff responsible for using the neighborhood dish machines will be educated on the policies and procedures related to the dish machine temperature log and the sanitation of dishes/dish machines. All nursing and dietary staff will be educated on this policy by 11/15/2024 via personal in-service. [Admin A initials] 11/07/2024. Beginning 11/07/2024, all staff responsible for using the neighborhood dish machines will be educated that if the dish machines do not reach 180 degrees F, they are to contact the Environmental Services Director. Beginning 11/07/2024, the Dietary Director, or designee, will audit the dish machine temperature logs. Audits will be daily for four weeks and weekly for two more months. The Dietary Director or designee will present the findings of the audit to the QAPI [Quality Assurance and Performance improvement] committee at their quarterly meeting for review and recommendation." The immediate jeopardy was removed on 11/7/24 at 4:06 p.m. after verification that the provider had implemented their removal plan. After the removal of the immediate jeopardy, the scope and severity of the citation level was "F" with guidance from the long-term care advisor for the South Dakota Department of Health.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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) COMPLETION DATE
F 812	Continued From page 59	F 812		

The current resident census was 52.

Review of the provider's November 2024 Kitchen Sanitation Policy revealed:
*"Purpose: To establish responsibilities for maintaining a clean and sanitary kitchen environment."
*"Responsibilities:"
-"Dietary Director"
--"Establish and maintain sanitary standards of cleanliness and food handling practices."
--"Ensure proper maintenance, operation and cleaning of all equipment."
-"Environmental Services:"
--" Preventative maintenance will be performed on equipment in the Nutrition Service Department."
*"Equipment Maintenance:"
-"All equipment used by Nutrition Services meets standards of the State Department of Health
-"The dishwasher is maintained and operated according to manufacturer's instructions. Hot water dish machines need to run at at 155 degrees for wash cycle and minimum of 180 degrees for rinse cycle."
-"Temperature/appropriate sanitation levels are checked & recorded daily."
-"All work surfaces and utensils are cleaned and sanitized after each use."
-"Cleaning schedules are posted & include frequency, position responsible & off when completed."

Review of the provider's January 2024 Sanitizer Preparation Policy revealed:
*"Purpose: Established the procedure to test sanitation solution for surface cleaning."
*"Prepare the sanitizer bucket according to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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) COMPLETION DATE
F 812	Continued From page 60 manufacturer's recommendation." *"Check expiration date on test strip canister to ensure they are not expired." *"Log what results are given by the test strip." 2. Observation on 11/6/24 at 11:30 a.m. of resident 25 being served lunch revealed: *Hospice certified nursing assistant (CNA) V assisted her to eat a sandwich. -She assisted with her bare hands giving her bites off the sandwich. -She then began cutting the sandwich with a fork and fed her bites from the fork but went back to handling the sandwich with her bare hands. Interview on 11/6/24 at with CNA V revealed she did not use gloves when she assisted residents to eat. She stated she would wash her hands or use hand sanitizer. Interview on 11/06/24 at 2:35 p.m. with director of nursing (DON) B revealed that CNA V should have worn gloves when handling the ready to serve sandwich. She stated she would have had the same training as her CNAs for handling ready to serve foods. Interview on 11/6/24 at 3:00 p.m. with DON B regarding orientation of a Hospice nursing assistant revealed they would shadow with one of her CNAs for one day. She did not have anything in writing or have them sign anything. Interview on 11/08/24 at 11:57 p.m. with CNA V revealed: *She stopped this surveyor in the hall and stated, "I should have worn gloves when handling resident 25's sandwich, I can't believe I did that." she stated she had more training yesterday 11/7/24.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	C 11/08/2024

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) COMPLETION DATE
F 812	Continued From page 61 Review of the provider's General Food Preparation and Handling policy dated 1/1/24 revealed, "5. Equipment f. Use tongs or other serving utensils to serve breads or other items. Never touch food directly with bare hands."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING 01 - MAIN B. WING	11/06/2024

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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 11/6/24 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 deficiency identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be	K 222	On 11/26/2024, the Environmental Services Director replaced the egress door keypad on Maple Valley and ensured it was functioning appropriately. All staff will be educated via in-service on 12/04/2024 on their roles in communicating if any egress doors are not functioning appropriately or are in need of repair. Beginning 12/02/2024, the Environmental Services Director, or designee, will audit that all egress doors are free from obstruction and that the keypads are functional and in good repair, if present, 1x per week for 3 months. The Environmental Services Director, or designee will present the findings of the audit to the QAPI committee for review and recommendation at their quarterly meeting.	12/10/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 12/02/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING **01 - MAIN** B. WING ______	**11/06/2024**

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) COMPLETION DATE
K 222	Continued From page 1 electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide operable egress doors	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING 01 - MAIN B. WING	11/06/2024

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) COMPLETION DATE
K 222	Continued From page 2 as required at one observed exit door location (exit door from Maple Valley neighborhood). Findings include: 1. Observation on 11/6/24 beginning at 9:05 a.m. revealed the exterior exit door from the Maple Valley neighborhood was unable to be easily opened. The neighborhood is a locked unit for memory care and doors may be unlocked by staff using a numeric code. Testing of the door by entering the code revealed it would not open. The maintenance supervisor first tried without success. A second staff was asked but said he could not get the door to function. a third staff member was successful. The number 3 on the keypad was not functioning correctly. Interview at the time of the observation with the maintenance supervisor confirmed those conditions. He stated he was unaware that door was not able to be opened. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.5.2(1)	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. BUILDING ______ B. WING ______	11/06/2024

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) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 11/6/24. Bethany Home - Brandon was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hunter Winkleplack	Administrator	12/02/2024

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

PRINTED: 11/25/2024
FORM APPROVED

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 ______	11/08/2024

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 11/5/24 through 11/8/24. Bethany Home - Brandon was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/5/24 through 11/8/24. Bethany Home- Brandon was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Hunter Winkleplack	Administrator	12/02/2024