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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 5/29/25. Areas surveyed included resident abuse and neglect, nursing services, resident rights, quality of care/treatment and education services. Bethany Home-Brandon was found not in compliance with the following requirements: F600, F689, and was found to have past non-compliance at F658.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: A. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI)reviews, observation, interview, record review, and policy review, the provider failed to protect the resident's right to be free from verbal and physical abuse by certified nursing assistant (CNA) K while providing assistance with undressing to one of	F 600	IDT reviewed the Policies and Procedures relating to abuse and neglect on 06/06/2025. CNA P, CNA D, CNA/CMA L, CNA F, RN G, CNA B, LPN C, ADON/MDS H and all staff will be educated on timely abuse/neglect reporting requirements and facility abuse/neglect policies and procedures by 06/13/2025 through directed in-serivce. Beginning 06/09/2025, all Bethany Department Heads will audit abuse and neglect through staff observation 20x per week for one month, 10x per week for one month, and 5 times per week for one month. IDT reviewed the care plan for resident 1 on 06/11/2025 to ensure that there were parameters in place for how to respond if the resident becomes combative. All resident care plans will be reviewed by 06/20/2025 to identify any other residents with behavioral concerns and that interventions are in place to address those concerns, if necessary. Beginning 06/16/2025, the DON, or designee, will audit resident care plans for behavioral interventions if residents have a history of behavioral concers 3x per week for one month, 2x per week for one month, and 1x per week for one month. A comprehensive list of residents using a bedpan will be gathered by 06/11/2025. IDT reviewed and revised, as necessary, the policies and procedures relating to bed pan use on 06/11/2025. CNA P, CNA D, CNA/CMA L, CNA F, RN G, CNA B	06/25/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 06/16/2025

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

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 one cognitively impaired sampled resident (1) dependent on staff assistance for activities of daily living (ADLs) and known resistance to care. Findings include: 1. Review of the provider's 1/20/25 submitted SD DOH FRI regarding certified nursing assistant (CNA) K's interaction with resident 1 revealed: *Resident 1 had "poor cognition" and resided in the secured memory care unit. *On the evening of 1/19/25 "[CNA K] was getting resident 1 ready for bed..." *CNA K [did not know I CNA/certified medication aide(CMA) L] "had walked into the room and she [CNA K] was getting frustrated because [resident 1] did not want to take off his sweater ..." *"CNA K was getting upset and was taking his [resident 1's] arm out of his sweatshirt aggressively and he verbally said 'ow'." *" ...DON [director of nursing (DON) A] spoke with [CNA K] regarding the above incident." -"[CNA K] states she went into [resident 1's] room around [9:00 p.m.] to get him ready for bed." -"She [CNA K] states [resident 1] starts hitting and kicking her. [CNA K] states she told [resident 1], 'no, I don't want to be hit.'" -"[CNA K] states she was able to get [resident 1]'s shirt off, but then had to pry it out of his hands." -"When questioned if he said 'ow' at any point, [CNA K] states he did when she pulled the shirt out of his hands." -"[Resident 1] continued to hit and kick [CNA K], and [CNA K] states she told [resident 1] she was not having this." -"[CNA K] states she was eventually able to get [resident 1] into bed." -"DON A informed [CNA K] she was suspended pending completion of the investigation." *Investigation Conclusion:	F 600	LPN C, ADON/MDS H and all staff will be educated on the facility's policy and procedure relating to bed pan usage by 06/20/2025 through directed in-service. Beginning 06/16/2025, the DON, or designee, will audit resident bed pan care delivery 3x per week for one month, 2x per week for one month, and 1x per week for one month. IDT will present the findings of all audits to the QAPI committee upon the audit timeline expiring for review and recommendation.	

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 2 -"Incident was reported on 1/19/2025 at 10:37 p.m., however this was not seen by DON [A] until the following day as it was reported via text message." -"[CNA K] was suspended on 1/20/2025 at noon." -"Resident [1] was assessed on 1/20/25 by the floor nurse. No injuries noted. No adverse effects noted. No signs of distress or fearfulness noted. Resident was not interviewed as he has poor cognition and would not understand." -"No other residents were interviewed as this incident occurred on our secured memory care unit where all residents would not be able to recall." -"No other staff members were interviewed as [CNA L] was the only other staff member actively working with the residents on that neighborhood." -"Nursing and administration is looking into dementia education programs and will be doing written education with all nursing staff on abuse and neglect." -"Will continue to monitor." -The question "Was abuse allegation substantiated?" was answered "Yes". -"[CNA K]'s statement acknowledged abuse." -"Personnel terminated" was documented in the "action taken by facility" area of the report. Observation on 5/29/25 at 8:48 a.m. of resident 1 in the memory care unit (MCU)'s dining room revealed: *He sat in his wheelchair and self-propelled his wheelchair around the dining room. *He was pleasantly confused and responded to a greeting, shook hands and responded to simple questions by laughing. Review of resident 1's electronic medical record (EMR) revealed:	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 3 *He was admitted to the facility on 1/23/24 to a room in the MCU. *His diagnoses included: Alzheimer's disease with late onset and moderate dementia, with other behavioral disturbance. *His current care plan included interventions: -"If resident resists with ADLs [activities of daily living], reassure resident, leave and return 5-10 minutes later and try again." -"I require staff assistance with all transfers with use of standing lift." -"I require staff assistance with all dressing, grooming, toileting and personal care tasks." *His 4/3/25 Brief Interview for Mental Status (BIMS) assessment score was zero indicated severe cognitive impairment. *A progress note on 1/20/25 at 7:46 a.m. indicated "Resident's skin assessed, no lumps, bumps or bruising present to upper extremities. Resident has full range of motion to BUE [bilateral upper extremities]. Does have small less than pea sized scab to right outer forearm. No redness or bruising surrounding. Resident does not appear to be pain or discomfort with passive range of motion." *There was no progress note related to the 1/19/25 incident noted above in the 1/20/25 submitted SD DOH FRI. Interview on 5/29/25 at 9:04 a.m. with CNA P in the MCU regarding resident 1 revealed: *He had worked at the facility since August 2024. *Resident 1 was not responsive most of the time but responded to conversation at times. *He felt resident 1 was "pretty good" this morning. *He recalled only one time that resident 1 was resistive to care and CNA P "got out of [the] way and let him cool off."	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 4 Interview on 5/29/25 at 11:36 a.m. with CNA D revealed: *She had worked at the facility since August 2024. *She felt no residents in particular were resistive to care in the MCU. *She felt resident's 1's reactions depended on "How you speak to him and interact with him." *If a resident was resistive to care, she stated if she could not calm the resident down, she would leave and reapproach the resident later, and added that five minutes later could make a big difference. Phone interview on 5/29/25 at 1:15 p.m. with CNA/CMA L revealed: *She had worked full-time on the night shift at the facility until recently. *She really enjoyed working on the MCU. *She stated a few of the residents on the MCU had mood or behavior problems and required redirection. * She stated some residents were resistive to care, but after giving the resident some time and reapproaching the resident later was most successful. Continued interview with CNA/CMA L regarding the incident on 1/19/25 with resident 1 and CNA K revealed: *It was her first time working with CNA K on 1/19/25. *She worked with CNA K from 8:00 p.m. to 10:00 p.m. that night. *She could not recall the exact time of the incident she observed, but stated she thought it was between 8:00 p.m. and 9:00 p.m. *She noticed CNA K had brought resident 1 to his room.	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 5 *CNA/CMA L entered resident 1's room to place the unplugged cord for the sit-to-stand mechanical lift that was lying on the ground back on the lift. *CNA K had not noticed CNA/CMA L in the room. CNA K was trying to get resident 1's shirt off and was visibly getting frustrated with him. CNA K yanked, on resident 1's arm to get his shirt off and stated, "come on [resident 1's first name]" and as he grabbed the shirt, CNA K tried to pry the shirt out of his hands. *Resident 1 exclaimed "ow" in response to CNA K's actions. *CNA/CMA L stated, "I was very uncomfortable with what I had observed." *CNA/CMA L felt after CNA K noticed CNA/CMA L in the room, CNA K tried to act differently and like she had not gotten upset with resident 1. *She questioned if she should have confronted CNA K or if she should have had a supervisor confront her. *After CNA K ended her shift and left the facility sometime after 10:00 p.m. that evening, CNA/CMA L asked the other medication aide on the MCU about the wording she had used in the text message to DON A about the incident. *She had not been in a situation of observing another CNA potentially verbally and physically abusing a resident before that incident on 1/19/25. *CNA/CMA L stated that DON A replied to her text message at 6:00 a.m. the next morning. Interview on 5/29/25 at 3:00 p.m. with DON A revealed: *CNA/CMA L's 1/19/25 text message was at 10:37 p.m. regarding the incident with CNA K and resident 1. *She had replied to that text message on 1/20/25	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 6 at 6:52 a.m. over eight hours later. *She expected staff to immediately inform the on-call nurse of allegations of potential abuse so the situation could be dealt with immediately *She stated, during the investigation of the incident, she had educated CNA/CMA L of the need to immediately report an incident by calling the on-call nurse. *Since the incident, no monitoring mechanisms were put in place to ensure staff notified the on-call nurse of suspected incidents of abuse if the DON was not in the building. Further interview on 5/29/25 at 5:12 p.m. with DON A revealed: *They had discussed dementia training for the staff with the regional ombudsman. *They had not scheduled or set up that dementia training. Review of the provider's 11/18/22 Resident Rights Guidelines revealed: *Purpose: "To provide general guidelines for resident rights while caring for the resident." *Preparation: "Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including:" -"Be free from verbal, ...physical, and mental abuse ... from anyone ..." *General Guidelines: " ...Ask permission to implement the procedure. If the resident refuses, notify your supervisor." Review of the provider's May 2025 Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating policy revealed: *"If resident abuse, ... is suspected, the suspicion must be reported immediately to the Director of	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 7 Nursing (DON) or designee." B. Based on SD DOH, FRI dated 4/29/25, record review, interview and policy review, the provider failed to protect the resident's right to be free from neglect by certified nursing assistant (CNA) F who left one of one cognitively impaired sampled resident (2) dependent on staff assistance with toileting needs and repositioning on a bedpan for an extended period of time that contributed to the resident developing a skin injury. Findings include: 2. Review of the provider's SD DOH FRI dated 4/29/25 with attached baseline care plan revealed: *This was a FRI for suspicion of abuse or neglect. *Resident 2 was found on a bedpan on 4/29/25 at 9:00 a.m. *Linear lines were noted on the resident's buttock that were slow to blanch (skin whitens in color temporarily/lacking blood flow to area). *Day shift staff indicated they had not placed resident 2 on a bedpan yet that day. *During nursing change of shift report the morning of 4/29/25 there was no indication that resident 2 was put onto a bedpan. *The provider's investigation indicated certified nursing assistant (CNA) F reported she had placed resident 2 on a bedpan around 2:00 a.m. that day. *CNA F was suspended on 4/30/25 pending further investigation by the provider. *The resident's primary care provider (PCP) and power of attorney (POA) were notified of the incident. *Resident 2's baseline care plan indicated: -She needed a Hoyer lift (mechanical lift and sling to lift a person's full body) for all transfers. -She used her wheelchair for mobility that was	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 8	F 600		

pushed by staff.
-She was unable to ambulate.
-She slept on a pressure guard mattress and sat on a pressure-reducing cushion in her wheelchair.
-She was continent of bowel and bladder.
-She used a bedpan for elimination of her bowel and bladder and required total staff assistance with her incontinence care.
-Staff were to encourage her to reposition frequently to promote my skin health.
-I am unable to take a bath currently, due to my surgical incision. Please assist me with bed bath twice weekly and as needed.
-I am receiving hospice services currently.

Review of resident 2's of electronic medical record (EMR) revealed:
*She was admitted to the facility on 4/21/25 and admitted to hospice services 4/22/25.
*Her diagnoses included:
-Acute Kidney Failure.
-Weakness.
*Her 4/22/25 Brief Interview for Mental Status (BIMS) assessment score was 6 which indicated she had severe cognitive impairment.
Resident 2's tasks (care needs provided by staff) included staff were to provide her:
-Repositioning as needed (PRN).
-She wore an incontinent brief.
-Toileting hygiene every day, evening, and night shift.
*Her toileting task by the staff was documented as completed at 2:27 a.m. on 4/29/25.
*A new physician's order was added 4/30/25 for Triad paste (a wound healing product) to her left buttock daily and PRN.
*A progress note dated 4/30/25 indicated:
-She had been left on a bedpan the previous day.

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 9 -Linear markings to her left buttock were parallel to each other, which would be consistent with the edge of a bedpan. -Those areas on her left buttock were slow to blanch. -An order to apply Triad paste to her left buttock was received and started. *Resident 2 passed away on 5/1/25. Interview on 5/29/25 at 2:32 p.m. with CNA F revealed: *Resident 2 was unable to reposition herself. *Resident 2 could use her call light to call for staff assistance. *The resident was on a repositioning schedule and was to be repositioned by the staff every two hours. *She had placed resident 2 on the bedpan between 2:00 a.m. and 3:00 a.m. on 4/29/25. *She then answered two additional resident's call lights. *She had forgotten she had placed resident 2 on the bedpan that day. *She was suspended from work during an investigation of the incident. *She completed the required education related to the incident prior to returning to working for provider. Interview on 5/29/25 at 2:45 p.m. with registered nurse (RN) G revealed: *She had worked on 4/28/25 at 6:00 p.m. until 4/29/25 at 6:00 a.m. *She had given resident 2 medication for pain between 8:00 p.m. and 10:00 p.m. on 4/28/25. *CNA F did not report to her that resident 2 was on a bedpan during that night shift. *She had not attended any education regarding the use of bedpans for residents.	F 600		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 10	F 600		

*Timers were to be used for up to 30 minutes when placing residents on bedpans to remind staff to check on the resident for removal of the bedpan.
*Residents needed to have call lights within reach.

Interview on 5/29/25 at 3:30 p.m. with CNA B revealed:
*She worked the morning shift on 4/29/25 that started at 6:00 a.m.
*Upon coming onto her shift, she walked around and checked on all of the residents.
*She got a report of the resident's status from the previous shift.
*She was told resident 2 had been changed at 5:00 a.m.
*She went into resident 2's room to complete her morning cares at 8:00 a.m. on 4/29/25 and discovered the resident was on the bedpan.
*After rolling her off the bedpan she observed a red mark on the resident's left buttock.
-There were no open areas on the resident's skin at that time.
*She recalled resident 2 had a previous deep tissue injury (DTI) on her coccyx when she had admitted to the facility.
*She reported the incident of the bed pan and red mark on the resident's buttock to licensed practical nurse (LPN) C.

Interview on 5/29/25 at 3:50 p.m. with LPN C revealed:
*She was the day nurse on 4/29/25 for resident 2's wing.
*She gave resident 2 her morning medications between 6:30 a.m. and 7:00 a.m. on 4/29/25.
*That morning CNA B told her that resident 2 had been found on the bedpan, she was unsure of 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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 11	F 600		

time.
*LPN C and assistant director of nursing (ADON)/Minimum Data Set (MDS) H assessed resident 2's buttocks after CNA B reported the concern to them.
*LPN C did not see a red circle from the bedpan at that time, but the resident's coccyx (tailbone) had a couple of red areas above it that were slow to blanch.
*A request was then sent to resident's PCP for Triad paste and foam to apply to the affected area.

Interview on 5/29/25 at 3:52 p.m. with ADON/MDS H revealed:
*She and LPN C assessed resident 2's buttocks on 4/29/25 after CNA B reported the concern to them.
*She observed an initial linear red mark, possibly from the bedpan being left under the resident too long, on resident 2's buttocks.
*No open areas or bleeding were noted at that time.
*Resident 2 had a previous DTI to her coccyx when she admitted to the facility.
*She had faxed resident 2's PCP and described what she found and what had occurred following the assessment to obtain a skin treatment order.

Interview on 5/29/25 at 5:20 p.m. with director of nursing (DON) A revealed:
*Bedpan education was given to the staff after the incident with resident 2 on 4/29/25.
-Timers were to be used for residents who used a bedpan.
-Staff were to set the timer for 10 minutes and check on the resident. If an additional 10 minutes was needed, then timer was to be reset.
-That process was implemented to ensure staff

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 12 returned to assist the residents. Review of the providers approved May 2025 Abuse, Neglect, Exploitation or Misappropriation Policy revealed: *"All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported." -"a. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." -"b. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress."	F 600		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, and interview, the provider failed to ensure correct documentation of controlled medications (medications with risk for abuse and addiction) when administered for one of one sampled resident (4). This citation is considered	F 658	Past noncompliance: no plan of correction required.	

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 13	F 658		

past non-compliance based on a review of the corrective actions the provider implemented following the incident.
Findings include:

1. Review of the provider's 2/6/25 SD DOH FRI for resident 4 revealed:
*Director of nursing (DON) A was notified by registered nurse (RN) E of concerns regarding licensed practical nurse (LPN) S that included:
-LPN S having left controlled medications sitting on top of a medication cart and unattended.
-LPN S having incorrectly documented the administration of resident 4's controlled medications.
*Initial evaluation of narcotic sheets showed LPN S had signed out three doses of lorazepam (a controlled antianxiety medication) 0.5 mg tablets on 2/5/25 at 9:00 a.m., 10:00 a.m., and 12:00 p.m.
-That medication card contained 29 tablets of lorazepam 0.5 mg tablets, while the controlled drug receipt/record/disposition form stated the count was 26 tablets.
*The oxycodone (a controlled pain medication) 5 mg half- tablets medication card contained 26 half-tablets. The narcotic (controlled medication) count sheet for the oxycodone stated the count was 29 tablets.
*Review of the resident's February medication administration record (MAR) revealed:
-LPN S signed out an as needed (PRN) dose of oxycodone at 10:16 a.m. on 2/5/25.
-LPN S signed out an PRN dose of oxycodone at 12:30 p.m. on 2/5/25.
-LPN S did not document any lorazepam medication was administered in the MAR on 2/5/25.
-LPN S did documented a scheduled lorazepam

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 14 tablet was administered at 2:37 p.m. on 2/5/25. -The MAR indicated a 2/5/25 at 3:00 a.m. dose of oxycodone 5 mg half-tablet was administered but, it was not signed out in the controlled drug receipt/record/disposition form by RN N. *A narcotic medication count took place on 2/5/25 at 6:00 a.m. with RN N and LPN S, and no discrepancies in the medication counts were noted by them, despite a missing signature for a 3:00 a.m. dose of PRN oxycodone that was given by RN N. *Narcotic counts on 2/5/25 at 4:00 p.m. between RN E and LPN S occurred and, RN E indicated LPN S needed to sign off her narcotic book. *It was undetermined if LPN S signed the narcotic book at the time of the request. *A narcotic count took place on 2/6/25 at 12:00 a.m. with RN E and LPN O with no discrepancies noted. *A narcotic count took place on 2/6/25 at 6:00 a.m. with LPN O and LPN S with no discrepancies noted. *Through the provider's investigation it was determined: -RN N had administered a dose of oxycodone to resident 4 on 2/5/25 and did not sign out that dose on the receipt/record/disposition form. -LPN S admitted she had incorrectly signed out three oxycodone doses under resident 4's lorazepam receipt/record/disposition form. -LPN S admitted she had not documented the administration of that medication in the MAR. -LPN S was placed on suspension on 2/6/25 pending completion of the provider's investigation. -LPN S employment at the facility was terminated on 2/6/25 following the completion of the provider's investigation.	F 658		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 15 2. Interview on 5/29/25 at 2:20 p.m. with RN E revealed: *On 2/5/25 her shift started at 4:00 p.m. *At the start of her shift that day she noted two unlabeled syringes with liquid in them on top of the medication cart. *LPN S was the nurse who worked the previous shift, and she was not at the medication cart at that time. *When RN E completed the narcotic count with LPN S they noted there were discrepancies to the count for resident 4's oxycodone and lorazepam medications. *She requested LPN S correct the narcotic record. *LPN S left that day without correcting the narcotic record. *RN E notified DON A of the narcotic record counts being off the evening of 2/5/25. *RN E had received education since the 2/5/25 incident occurred from the providers pharmacy regarding controlled substances and correct documentation. Interview on 5/29/25 at 5:20 p.m. with DON A revealed: *LPN S was terminated on 2/6/25 after the provider's investigation into the controlled counts for resident 4 was completed. *The providers pharmacy completed staff education regarding narcotics and documentation with nursing staff. *Audits were completed and documented signed out in MAR, signed out on narcotic receipt/record/disposition form, and narcotic counts are correct. -Audits were completed on all units. -completed at least twice weekly.	F 658		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 16 The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 5/29/25 after a record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding medication administration and diversion education, interviews revealed that staff understood the education provided regarding those topics, review of narcotic records for three of the four wings revealed with no further missing documentation of narcotic records for current residents, and a review of providers Controlled substances policy dated 2/25 confirmed processes for accountability of controlled medications. Based on the above information, non-compliance at F658 occurred on 2/5/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 5/29/25, the non-compliance is considered past non-compliance.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider	F 689	All residents in wheelchairs had their wheelchairs assessed on 06/11/2025 to ensure that all wheelchairs had wheelchair pedals in their bag on the back of the wheelchair. IDT, in collaboration with the Medical Director, reviewed and revised, as necessary, the policies and procedures relating to wheelchair pedal use on 06/16/2025. CNA D, LPN R and all staff will be educated on the facility's policy and procedure surrounding wheelchair pedal use by 06/20/2025 via directed inservice. Beginning 06/16/2025, DON, or designee, will audit that all residents in wheelchairs have wheelchair pedals and that staff are properly using wheelchair pedals 5x per week for one month, 3x per week for one month, and 2x a week for one more month.	06/25/2025

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17 failed to ensure the safety of one of one sampled resident (3) who fell out of her wheelchair and received a laceration to the left side of her forehead that required sutures. The fall was related to assistive devices (wheelchair pedals) not being in place to prevent an accident. Findings include: 1. Review of the provider's 3/15/25 SD DOH FRI regarding resident 3 revealed: *On 3/15/25 at 8:30 a.m. certified nursing assistant (CNA) Q yelled out while in resident 3's room. *CNA D responded and went to assist resident 3 in her room and alerted licensed practical nurse (LPN) R that resident 3 was on the floor. *LPN R entered the room and found resident 3 lying on the floor on her left side and bleeding from the left side of her forehead from an "approximately ½ inch laceration with immediate swelling/bruising to forehead with bleeding unable to be controlled with pressure at this time." *"911 called and resident [was] picked up via ambulance." *"[Resident 3] returned with sutures in her head." *"Resident's fall was due to no wheelchair petals [pedals] on her wheelchair." 2. Review of resident 3's closed electronic medical record (EMR) revealed: *She was admitted to the facility on 2/27/25. *Her diagnoses included traumatic subdural hemorrhage with loss of consciousness, repeated falls, and unspecified dementia with other behavioral disturbance. *Her 3/5/25 Brief Interview for Mental Status (BIMS) assessment score was ten which indicated she was moderately cognitively impaired.	F 689	DON, or designee, will present the findings of the audit to the QAPI committee upon the audit timeline expiring for review and recommendation	

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18 *A progress note on 3/15/25 at 11:49 a.m. indicated: -"Writer heard CNA yell out while in resident's room. 2nd CNA went to assist and alerted writer that resident was on the floor. Upon entering the room, resident was laying on left side and bleeding from left side of forehead. CNA applied pressure to wound after writer assessed wound. Noted approximately half inch laceration with immediate swelling/bruising to forehead with bleeding unable to be controlled with pressure at this time. Assessed noted injury, ..." *A progress note on 3/15/25 at 2:15 p.m. indicated: -"Resident returns from ED [emergency department] at 1345 [1:45 p.m.] via wheelchair express. Paperwork returned to writer ... Generally confused at this time. Resident received 3 sutures to [her] left forehead. Will continue neuro [neurological] checks for fall/hitting head." *Her comprehensive care plan revealed: -A focus area that indicated "I am at risk for falls." -Interventions that included: --"I have reported 4-5 falls in the past 6 months, one of which resulted in my subdural hematoma and is why I am here at [provider's name]". --"I suffered a witnessed fall ... on 3/15 that resulted in an injury to my head. I was transported to the hospital for evaluation. I fell forward out of my wheelchair as I was being propelled by staff ..." *On 5/6/25, resident 3 was transferred to another nursing home. 3. Interview on 5/29/25 at 11:36 a.m. with CNA D revealed: *She had worked at the facility since August 2024.	F 689		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 19 *Regarding how to ensure the safety of residents using wheelchairs she stated "Wheelchair pedals, those are a must" and stated they had an incident related to that a couple of months ago. *Regarding that incident, she stated: -She worked the morning of 3/15/25 with another CNA Q and was serving breakfast when she heard a gasp, and she walked into the room and found resident 3 on the floor. -CNA Q stated to her that she did not know what happened. -CNA D stated that resident 3 needed wheelchair pedals as she could walk and would often propel herself in her wheelchair, and her would catch on the floor when transporting her in her wheelchair without the pedals. -She stated CNA Q had been working at the facility longer than she had, so she should have known that. -She stated there was training provided following that incident that included reading and signing an information sheet regarding the importance of using wheelchair pedals with residents. Interview on 5/29/25 at 3:00 p.m. with director of nursing (DON) A revealed: *She stated the training on the use of wheelchair foot pedals with residents was provided on 3/15/25. *She expected staff to use wheelchair pedals with residents while transporting them. *No monitoring mechanism had been put in place to ensure staff used wheelchair pedals when transporting residents. *She stated that during her daily rounds she had observed to ensure foot pedals were in use on residents' wheelchair, but she had not documented those observations.	F 689		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 20 Interview on 5/29/25 at 3:39 p.m. with LPN R revealed: *She recalled resident 3 and the incident that occurred on 3/15/25. *She had heard CNA Q yell out in surprise. *CNA D then stated, "She's on the floor." *LPN R entered resident 3's room to assess the resident. *She stated resident 3 was on the floor in front of her wheelchair. *There was bleeding on the left side of her forehead and she could tell she needed stitches. *She had not worked much with CNA Q. *She indicated that CNA Q stated resident 3 had just fallen forward out of her wheelchair. *She stated she had called DON A to let her know about the situation as the resident went to the emergency department. *She stated that DON A had contacted her later that afternoon to ask if she had checked the wheelchair to ensure the foot pedals had been used. *LPN R stated she went to look at resident 3's wheelchair and discovered there were no foot pedals on her wheelchair. *LPN R stated the use wheelchair pedals was common sense. *She felt the provider had addressed the situation appropriately as they immediately suspended CNA Q and then ended up terminating her employment. *She recalled that written education regarding the required use foot pedals was provided and that it had been addressed at the next staff meeting. 4. Review of the provider's 2/2/21 Use of Wheelchair Pedals policy revealed: *Purpose: "To ensure each resident who uses a wheelchair had wheelchair foot pedals available	F 689		

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 05/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 21 and used properly to prevent accidents." *"Foot pedals will be used for residents who use wheelchairs while they are in their wheelchair, unless deemed safe and care planned otherwise." *"Foot pedals will be provided for each wheelchair used by a resident for mobility." Review of the requested list of the current 54 residents revealed 48 of those residents required the use of a wheelchair.	F 689		