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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		435096	B. WING _			C 12/05/2024
NAME OF PROVIDER OR SUPPLIER BETHANY HOME SIOUX FALLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1901 SOUTH HOLLY AVENUE SIOUX FALLS, SD 57105		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 000	CFR Part 483, Subp Term Care facilities of The areas surveyed and staffing related to facility by exiting from while staff were proving residents. Bethany Fin compliance.	survey for compliance with 42 art B, requirements for Long was conducted on 12/5/24. were physical environment to a resident who left the m a delayed egress door	FC	TITLE		(X6) DATE

Deborah Herrboldt Administrator 12/16/2024

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.