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 _____	07/20/2023

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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/18/23 through 7/1/20/23. Bethany Home - Brandon was found not in compliance with the following requirements: F554, F559, F658, and F880.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure physician's orders and self-administration of medication assessments had been completed for one of three sampled residents (34). Findings include: 1. Observation and interview on 7/19/23 at 2:38 p.m. with resident 34 revealed she: *Was at the nurse's station seated in her wheelchair. *Had a clear plastic medication cup that contained multiple pills and tablets placed in her lap. *Would take them to her room and administer them herself. *Had several empty medication cups on different surfaces in her room. *Stated she had taken the medications. "I take them by myself to keep my independence."	F 554	Resident 34 was assessed on 08/03/2023 to determine if they were appropriate to Self Administer their own medications. All resident Self Administration orders were reviewed on 08/03/2023 to ensure they were current and that no changes were needed. IDT reviewed and revised, as necessary, the policies and procedures related to resident Self Administration of Medications on 08/03/2023. DON or designee will hold a directed inservice on 08/15/2023 for RN E and all staff regarding the facility's policies and procedures for resident Self Administration of Medication. Beginning 08/07/2023, DON or designee will audit medication administration to ensure staff are properly administering medicaitons. Audits will be 3x per week for 4 weeks, 2x per week for next 4 weeks, and 1x per week for 4 for weeks. Beginning 08/07/2023, DON or designee will audit resident self administration orders to ensure the orders are current and that they have all of the required documentation. Audits will be once per week for 3 months. DON or designee will present the findings of the audit to the QAPI committe monthly for review and recommendation.	09/03/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 08/07/2023

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 _____	07/20/2023

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 554	Continued From page 1 Review resident 24's of medical record revealed an assessment signed by the nurse, physician, and pharmacist to only have cough drops and a nebulizer medication as self-administration medications. Interview on 7/19/23 at 3:50 p.m. with registered nurse (RN) E revealed: *She had given resident 34 her 2:00 p.m. medications. *She had always let resident 34 take her medications to her room and self-administer. *She was unaware resident 34 had required a physician order and a self-administration of medication assessment to have been able to self-administer her own medications. *"Resident 34 doesn't like anyone to watch her take her pills." Interview on 7/19/23 at 4:55 p.m. with director of nursing B revealed resident 34 had only been approved for self-administration of medications for cough drops and administering her nebulized medication after the nurse had set it up. RN E should not have let resident 34 take the medications to her room and should have observed her taking those pills. Review of the provider's July 2023 Self-Administration of Medications policy revealed: *"Resident's have the right to self-administer medications if the interdisciplinary team and the resident's attending physician and consulting pharmacists have determined that it is clinically appropriate and safe for the resident to do so." *"At least every three months, the licensed nurse, pharmacist and attending physician shall evaluate and record the continued appropriateness of the	F 554		

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 _____	07/20/2023

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 554	Continued From page 2 resident's ability to self-administer medications." *"No resident may keep medications of the resident's person in the resident's room without a medication order allowing self-administration."	F 554		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (38) was given advanced notification that she would have been getting a roommate. Findings include: 1. Interview on 7/18/23 at 2:05 p.m. with resident 38 regarding the new roommate revealed: *She was not able to state that she had received a notice from the facility that she would have been getting a roommate. *She was not happy that she had a roommate. Review of resident 32's progress notes revealed: *Licensed Clinical Social Worker (LCSW) C had	F 559	Resident 38 and all residents in a double room will be provided with written notice of the potential for roommates while occupying those rooms on 08/07/2023. IDT reviewed and revised, as necessary, the policies and procedures related to roommate notifcation and choice and the policies and procedures related to room change notification. Administratior held a directed inservice for LCSW C and all staff regarding the facility's policies and procedures related to resident roommates and resident room moves. Beginning 08/07/2023, facility Social Worker will audit all double room residents to ensure they have the proper written notification of the possibility for a roommate once a week for 3 months. Beginning 08/07/2023, Social Worker will also audit that all residents who are moving rooms within the facility have been properly notified and consulted once a weekfor 3 months. Social Worker or designee will present the findings of the audit to the QAPI committee monthly for review and recommendation.	09/03/2023

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 _____	07/20/2023

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 559	Continued From page 3 informed resident's family member on 6/28/23 at 2:14 p.m. that they would be moving her in with another resident when she was off of COVID isolation. Review of resident 38's progress notes revealed: *LCSW C had informed resident's family on 7/12/23 at 2.:36 p.m. by email that " ...Mom did get a roommate today." *There had been no previous communication with resident's family about her getting a roommate. Interview with LCSW C on 7/20/23 at 10:06 a.m. revealed: *She was not aware that the facility needed to give any notification when a resident was getting a roommate. *She assumed that resident 38 had known she would be getting a roommate at some time since she was in a double room. *Resident 38 was not notified of the roommate until the day the roommate moved in. *She assumed that resident 38 would have been okay with a roommate since she had a roommate in the previous facility where she had lived. Interview with Administrator A on 7/20/23 at 2:18 p.m. revealed he: *Was not aware that a resident needed to have advanced notice when getting a roommate. *Was not aware that the facility had a policy regarding roommates. *Had verbalized to the resident at admission that there was a possibility that since resident 38 was in a double room that she might get a roommate at some point. *Agreed the facility should have provided written notice to resident 38 before the new roommate moved in.	F 559		

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 _____	07/20/2023

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 559	Continued From page 4 Review of facility's 8/25/22 Resident Roommate Choice Policy revealed: *"Policy Interpretation and Implementation" -"2. Existing residents will be provided with a written notice of need for a roommate or roommate change with as much notice as possible." -"4. Written consent for choice of roommate and/or agreement with a roommate assignment will be obtained prior to roommate placement."	F 559		
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 observation, interview, record review, and policy review, the provider failed to ensure one of one registered nurse (RN) E and one of one certified nurse aide/medication aide (CNA/MA) M had administered medications according to the provider's policy for two of two sampled residents (34 and 46). Findings include: 1. Observation and interview on 7/19/23 at 2:38 p.m. with resident 34 revealed she: *Was at the nurse's station seated in her wheelchair. *Had a clear plastic medication cup that contained multiple pills and tablets placed in her lap. *Would take them to her room and administer them herself.	F 658	Resident 34 and resident 46 were assessed on 08/03/2023 to determine if they were appropriate to Self Administer thierown medications. All resident Self Administration orders were reviewed on 08/03/2023 to ensure they were current and that no changes were needed. IDT reviewed and revised, as necessary, the policies and procedures related to resident Self Administration of Medication and proper Medication Administration by staff on 08/03/2023. A directed in-services will be held on 08/15/2023 by the DON or their designee regarding the facility's policies and procedures related to Medication Administration and Resident Self Administration of Medication. Beginning 08/07/2023, DON or designee will audit medication administration to ensure that staff are properly administering medications. Audits will be 3x per week for 4 weeks, 2x per week for 4 more weeks, and 1x per week for 4 more weeks. Beginning 08/07/2023, DON or designee will audit resident self adminstration orders to ensure they are current and have all of the required documentation. Audits will be once a week for 3 months. DON or designee will present the findings of the audit to the QAPI committee monthly for review and recommendation.	09/03/2023

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 _____	07/20/2023

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 5 *Had several empty medication cups on different surfaces in her room. *Stated she had taken the medications. "I take them by myself to keep my independence." Review resident 24's of medical record revealed an assessment signed by the nurse, physician, and pharmacist to only have cough drops and a nebulizer medication as self-administration medications. Interview on 7/19/23 at 3:50 p.m. with registered nurse (RN) E revealed: *She had given resident 34 her 2:00 p.m. medications. *She had always let resident 34 take her medications to her room and self-administer. *She was unaware resident 34 had required a physician order and a self-administration of medication assessment to have been able to self-administer her own medications. *"Resident 34 doesn't like anyone to watch her take her pills." Interview on 7/19/23 at 4:55 p.m. with director of nursing B revealed resident 34 had only been approved for self-administration of medications for cough drops and administering her nebulized medication after the nurse had set it up. RN E should not have let resident 34 take the medications to her room and should have observed her taking those pills. Review of the provider's July 2023 Self-Administration of Medications policy revealed: *"Resident's have the right to self-administer medications if the interdisciplinary team and the resident's attending physician and consulting	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 _____	07/20/2023

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 6 pharmacists have determined that it is clinically appropriate and safe for the resident to do so." *"At least every three months, the licensed nurse, pharmacist and attending physician shall evaluate and record the continued appropriateness of the resident's ability to self-administer medications." *"No resident may keep medications of the resident's person in the resident's room without a medication order allowing self-administration." 2. Observation on 7/20/23 at 7:51 a.m. of CNA/MA M revealed she: *Placed 17 grams (gm) of MiraLAX powder into resident 46's glass of cranberry juice. *Placed the glass of cranberry juice onto resident 46's breakfast tray. *Medication for resident 46 had been placed on her breakfast tray. -Medications that had been prepared included: --Allopurinol Tablet 100 milligram (mg) by mouth. --Certa Vite/Antioxidants one tablet by mouth. --Folic Acid 1 mg by mouth. --Lasix 80 mg by mouth. --Meloxicam 15 mg by mouth. --MiraLAX Powder 17 gm/scoop 1 scoop. --Nameda 5 mg by mouth. --Metoprolol 50 mg by mouth. --Senna 8.6 mg tablet 1 tablet by mouth. --Tramadol 50 mg by mouth for moderate pain. ---Pain rating 0/10. -Vitamin C 500 mg by mouth. -Gabapentin 400 mgby mouth. *RN E delivered the breakfast tray to resident 46's room and then returned to the nursing area without ensuring the resident had taken her medication. Interview on 7/20/23 at 8:00 a.m. with CNA/MA M regarding resident 46's medication revealed:	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 _____	07/20/2023

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 7 *She had prepared resident 46's medication and placed them on the breakfast tray. *RN E had taken the tray into the resident's room. *All the medication RN E had delivered to resident 46's room had been signed off on 7/20/23 at 8:00 a.m. by CNA/MA M. Interview on 7/20/23 at 8:15 a.m. with resident 46 regarding her morning medication that were administered revealed: *She usually ate her breakfast in her room and her medication would be on her tray. *Staff did not stay in her room to make sure she had taken her medication. Interview on 7/20/23 at 2:30 p.m. with director of nursing (DON) B regarding the above observation revealed: *Staff that dispensed the medication from the medication card should have been the person to administer the medication. *Staff should have stayed in the resident's room to make sure the medication had been taken by the resident. Review of the provider's June 2023 Medication Administration Policy revealed: *Medication was not to have been left unattended. The nurse or MA must visualize the resident taking their medication. *Residents may self-administer their own medication only if the physician in conjunction with the interdisciplinary care planning team, had determined that they have the decision-making capacity to do so safely. *A person may not administer medications that have been prepared by another person.	F 658		
F 880 SS=E	Infection Prevention & Control	F 880	Meeting held with Great Plains QIN on 08/04/2023	09/03/2023

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 _____	07/20/2023

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 880	Continued From page 8 CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a	F 880	to discuss the root cause of the cited incidents. Discussion included establishing the 5 why's for each of the cited incidents and other opportunities for continued improvement in Infection Prevention and Control. Great Plains QIN shared multiple resources for the facility to take advantage of to improve its Infection Prevention and Control Programs. 5 why's are included in the Plans of Correction below. Resident 16's and Resident 40's dressing change orders were reviewed by 08/04/2023 and changes were made, if necessary. All facility resident's dressing change orders were reviewed by 08/04/2023 and changes were made if necessary. IDT reviewed and revised, as necessary, the Policies and Procedures related to dressing changes and hand hygiene on 08/03/2023. DON or designee will hold a directed in-service on 08/15/2023 for RN E, LPN F, and all staff regarding facility policies and procedures related to dressing changes and hand hygiene. Beginning 08/07/2023, DON or designee will audit dressing changes to ensure proper infection control procedures are being followed. Audits will be 2x per week for 4 weeks and then weekly for 2 more months. DON or designee will present the findings of the audit to the QAPI committee monthly for review and recommendations. 5 Whys: 1. Hand Hygiene for Dressing Changes were not performed correctly. 2. Human Error while performing the dressing changes. 3. Staff were either not competent or complacent with improper techniques during dressing changes. 4. Staff are not audited enough on their competency for dressing changes. Resident 29's and all facility resident's care plans were reviewed and changes were made, if necessary, on their individual toileting needs. IDT reviewed and revised, as necessary, the policies and procedures related proper hand hygiene on 08/03/2023. DON or designee will hold a directed in-service on 08/15/2023 for CNA N and all staff regarding proper toileting procedures and hany hygiene.	

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 _____	07/20/2023

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 880	Continued From page 9 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure infection prevention and control practices had been maintained for the following: *Hand hygiene and glove use for two of three observed resident (16 and 40) dressing changes by two of two registered nurses (RN) (E and L) and one of one licensed practical nurse (LPN) F. *Hand hygiene and glove use during personal care for two of four observed residents (15 and	F 880	Beginning 08/07/2023, DON or designee will audit resident toileting and hand hygiene to ensure proper infection control practices are being followed. Audits will be 2x per week for 4 weeks and then weekly for 2 more months. DON or designee will present the findings of the audit to the QAPI committee monthly for reivew and recommendation. 5 why's: 1. Staff were not following proper hand hygiene procedures while toileting resident 29. 2. Human error while toileting the resident. 3. Lack of competency or complancency with improper technique for resident toileting. 4. Staff are not audited for competency during resident toileting frequently enough. IDT reviewed and revised the policies and procedures, as necessary, for bloodborne pathogen control. DON or designee will hold a directed inservice on 08/15/2023 for RNL and all staff regarding the facility's policies and procedures for bloodborne pathogen control. Beginning 08/07/2023, DON or designee will audit treatments that may cause bloodborne pathogen exposure to ensure proper infection control practices are practiced. Audits will be 2x per week for 4 weeks and 1x per week for 2 more months. 5 whys: 1. Staff were not following proper infection control practices while dealing with bloodborne pathogen exposure. 2. Human error in bloodborne pathogen control. 3. Staff were either not competent or complacent in improper steps to deal with bloodborne pathogen exposure. 4. Staff are not audited for competency on bloodborne pathogen control frequently enough. DON or designee will present the findings of the audit to the QAPI committee monthly for reivew and receommendation.	

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 _____	07/20/2023

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 880	Continued From page 10 29) by certified nursing assistant (CNA (N) and LPN D. *Hand hygiene and glove use by one of one RN (L) for two of two observed residents (42 and 44) in the dining room. Findings included: 1. Observation on 7/18/23 at 10:36 a.m. with CNA N while she assisted resident 29 to the toilet revealed she: *Put on gloves without any hand hygiene. *Assisted resident 29 from her wheelchair to the toilet. *Removed the soiled pull-up brief and placed the brief in the garbage bag. *Looked for some wet wipes in the bathroom, including opening up resident 29's roommate's storage bin. *Removed the gloves and without performing hand hygiene left the room. *Returned a few minutes later to the resident's room with a new package of wet wipes. *Put on a pair of gloves without performing hand hygiene. *Assisted the resident to a standing position. *Performed perineal care after the resident urinated a small amount when she had stood up. *Helped resident 8 to pull up the brief and pants. *Put the soiled brief in a bag, removed her gloves, took the garbage bag down the hall, and disposed of it in the garbage. 2. Observation on 7/18/23 at 11:45 a.m. of RN L revealed she was assisting residents to eat lunch in the dining room. Resident 42 had a bloody nose. RN L took a tissue and rolled the end up slightly and then put it in the residents right nostril. She then took the tissue out of the resident's nostril. She had not completed hand hygiene after helping resident 42 with the bloody	F 880	DON will hold a directed in-service for RN L and all staff regarding hand hygiene after touching resident feet. Resident 15's and all resident's pressure ulcer treatment plans were reviewed by 08/04/2023 and changes were made if necessary. IDT reviewed and revised the policies and procedures related to wound care and hand hygiene on 08/03/2023. DON or designee will hold a directed in-service on 08/15/2023 for LPN F and all staff regarding proper hand hygiene during resident personal cares and wound cares. Beginning 08/07/2023, DON or designee will audit hand hygiene during wound care and personal cares. Audits will be 2x per week for 4 weeks and 2x per week for 2 more months. DON or designee will present the findings of the audit to the QAPI committee monthly for review and recommendation. 5 why's: 1. Staff did not use proper hand hygiene when treating a resident's pressure ulcer. 2. Human error while performing the resident's treatment. 3. Staff were either not competent or complacent with improper techniques when providing personal cares. 4. Staff are not audited for competency frequently enough.	

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 _____	07/20/2023

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 880	Continued From page 11 nose and then went back to assist resident 2. 3. Observation on 7/19/23 at 8:00 a.m. revealed resident 44 complained that her toes hurt. RN L took off her sock looked at and touched resident 44's toes. She put the sock back on her foot. She had not put on gloves prior to looking at or touching resident 44's toes. RN L had not completed any hand hygiene and returned to assisting other residents with breakfast. 4. Observation on 7/19/23 at 8:25 a.m. revealed RN's E and L entered resident 42's room for a dressing change to her left lower leg. *Both RN E and RN L put on gloves after washing their hands for less than five seconds and shut off the faucet with their wet bare hands. *RN L moved the garbage can closer to the overbed table and moved the items off of the table. She then put a towel on top of the overbed table. She had forgot an item and left the room to retrieve it. During that time RN E put on a pair of gloves and removed the soiled dressing from resident 40's left lower leg. She removed her gloves and washed her hands for less than five seconds and shut off the faucet with her wet bare hands. RN L returned and washed her hands for less than five seconds and shut off the faucet with her wet bare hands, and she put on a pair of gloves. She used wound wash to cleanse the skin tear, covered the wound with a Telfa-Tegaderm dressing. She removed her gloves, retrieved a marker from her uniform pocket and initialed & dated the dressing. She disposed of the dressing packages. Both RN's washed hands for less than 5 seconds and shut the faucet off with their bare wet hands. Interview on 7/20/23 at 9:30 a.m. RN L regarding	F 880		

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 _____	07/20/2023

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 880	Continued From page 12 the missed opportunities for hand hygiene and glove changes. She agreed she should have changed gloves between the cleansing of the wound and applying the new dressing. She agreed she had not completed hand hygiene per the provider's policy for the above observations. Interview on 07/20/23 at 11:30 a.m. with director of nursing B regarding the above findings agreed there had been several missed opportunities for hand hygiene. She agreed the hand hygiene completed was not up to the standards of practice. 5. Observation and interview on 7/19/23 at 2:00 p.m. of LPN F during resident 16's dressing change revealed: *She had performed hand hygiene and donned gloves before removing the resident's soiled dressing. *After she had removed the resident's soiled dressing she removed her gloves. *No hand hygiene was observed before she had placed on clean gloves. *A new dressing was then placed on the resident's wound. *LPN F agreed she should have performed hand hygiene after removing her soiled gloves and before putting on a pair of clean gloves. 6. Observation on 7/19/23 at 3:07 p.m. of LPN D during resident 15's personal care revealed: *The resident was in her bathroom and was seated on the toilet. *She had dime-sized pressure wounds on her bilateral buttocks that were covered with a layer of barrier cream. *LPN washed her hands for five seconds in the resident's bathroom before putting on a clean pair	F 880		

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 _____	07/20/2023

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 880	Continued From page 13 of gloves. *LPN then cleansed the resident's perineal area. *LPN placed a new layer of barrier cream to the resident's bilateral buttocks. -There was no observation of LPN D removing her soiled gloves, performing hand hygiene, and putting on a clean pair of gloves before applying a new layer of barrier cream on her bilateral buttocks. Review of the provider's revised September 2012 Infection Control Guidelines for All Nursing Procedures policy revealed: *Employees must wash their hands for twenty seconds with soap and water that included the following conditions: -Before and after direct contact with residents. -After removing gloves. *If hands were not visibly soiled, staff may use an alcohol-based hand rub for all of the following situations: -Before and after direct contact with residents. -Before handling clean or soiled dressing. -Before moving from a contaminated body site to a clean body site during resident care. -After handling used dressings.	F 880		

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 _____	07/20/2023

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 from 7/18/23 through 7/20/23. Bethany Home - Brandon was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 08/07/2023

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 _____	**07/19/2023**

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 for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/19/23. Bethany Home - Brandon was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack
TITLE: Administrator
(X6) DATE: 08/07/2023

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.

RECEIVED
AUG 07 2023
SD DOH-OLC

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 _____	07/20/2023

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 7/18/23 through 7/20/23. Bethany Home - Brandon was found not in compliance with the following requirements: S199 and S206.	S 000		
S 199	44:73:04:04 Personnel The facility shall have a sufficient number of qualified personnel to provide effective and safe care. Staff members on duty shall be awake at all times. Any supervisor shall be 18 years of age or older. Written job descriptions and personnel policies and procedures shall be made available to personnel of all departments and services. The facility may not knowingly employ any person with a conviction for abusing another person. The facility shall establish and follow policies regarding special duty or staff members on contract. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and personnel file review, the provider failed to follow their policy to complete background checks for two of five newly hired dietary employees (dietary aide H and cook I). Findings include: 1. Interview and review on 7/20/23 at 2:58 p.m. with human resources director G of dietary aide H and cook I's personnel files revealed: *Dietary aide H had been hired on 2/1/23. *Cook I had been hired on 5/28/23. *He had been the person responsible to ensure employee files were complete with all required documents and training, including background checks.	S 199	Dietary aide H and Cook I both had their background checks completed by 08/15/2023. Beginning 08/15/2023, HR Director or designee will review all staff records to ensure that all staff have recieved a background check and perform a background check if one had not been completed. IDT will review and revise, as necessary, the policies and procedures related to employee background checks. HR Director will hold an all staff inservice on 08/15/2023 to educate staff on the policies and procedures related to background checks. Beginning 08/15/2023, HR Director or designee will audit all new staff member files to ensure that a background check has been completed. Audits will be once a week for 3 months. HR Director or designee will present the findings of the audit at the quarterly QAPI meeting for review and recommendations.	09/03/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hunter Winkleplack

TITLE: Administrator

(X6) DATE: 08/07/2023

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 _____	07/20/2023

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 199	Continued From page 1 *It was their policy to complete background checks on all newly hired employees. *The above individuals had not had a background check completed and should have prior to their start date. *Those background checks had been missed. Review of the provider's 2023 employee handbook revealed: *"It is the policy of [facility name] to conduct a criminal record search on each newly employed person". *"[Facility name] will enforce policies and procedures that protect each resident from abuse, neglect, and misappropriation on property by [facility name] employees, other residents, consultants, volunteers, employees of other agencies serving the resident, family members and legal guardians, friends or other individuals".	S 199		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory	S 206	Dietary Aides H and I and Cooks J and K and all staff were educated on food safety, handwashing, food handling/preparation, foodborne illness, serving/distribution, leftovers, time/temperature controls, nutrition/hydration, and sanitation on 08/15/2023 at the directed inservice. IDT reviewed and revised, as necessary, the policies related to personnel training on 08/03/2023. Beginning on 08/15/2023, HR Director or designee will audit staff records to ensure that all current staff have recieved their proper trainings. Also beginning 08/15/2023, HR Director or designee will audit new employee files for personnel training completion. Both audits will be once a week for 3 months. HR Director or designee will present the findings of audit to the QAPI committee at their quarterly meeting for review and recommendation.	09/03/2023

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 _____	07/20/2023

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 206	Continued From page 2 reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and personnel file review, the provider failed to have a formal orientation and an ongoing education program for four of five sampled dietary employees (dietary aides H and I, cooks J, and K). Findings include: 1. Interview and review on 7/20/23 at 2:58 p.m. with human resource director G of sampled dietary employees revealed: *There was no documentation in the personnel files for dietary aide H hired on 2/1/23 and cook J hired on 5/28/23 they had received orientation training in: -Food safety. -Handwashing. -Food handling/preparation. -Foodborne illness. -Serving/distribution. -Leftovers. -Time/temperature controls. -Nutrition/hydration. -Sanitation. *There was no documentation in the personnel	S 206		

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 _____	07/20/2023

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 206	Continued From page 3 files for cook K hired on 9/20/21 and dietary aide I hired on 2/14/2022 had recieved ongoing education for the above identified required topics. *He had not ensured the required orientation training or ongoing education to the above employees had been completed. *He confirmed the expectation was to have followed the regulation and provide their employees the required orientation and ongoing training.	S 206		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/18/23 through 7/20/23. Bethany Home - Brandon was found in compliance.	S 000		