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

PRINTED: 01/31/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		435080	B. WING		444	01/30/2024	
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHESDA OF BERESFORD				6	606 W CEDAR		
DETRESON OF BERESPORD				E	SERESFORD, SD 57004		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID		PROVIDER'S PLAN OF CORRECTION		(VE)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI	X		(EACH CORRECTIVE ACTION SHOULD BE COMPLETION	
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIATE DA		
					DEFICIENCY)		
F 000	0 INITIAL COMMENTS		F 00				
	A complaint health survey for compliance with 42				The state of the s		
	CFR Part 483, Subpart B, requirements for Long						
		as conducted from 1/29/24					
	through 1/30/24, Area						
	qualified personnel and dietary services.				1		
		d was found in compliance.					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE
HOWX WY					Administrator	C	1/31/24

Any deficiency statement ending with an asterisk (Calence a defit the which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient projection 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 cellicericies are cited, an approved plan of correction is requisite to continued program participation.

FEB 0 1 2024

FORM CMS-2567(02-99) Previous Versions Obsolute.....

Event ID: K7N811

SD DUM-OLC

Facility ID: 0022

If continuation sheet Page 1 of 1