STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435071	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home	129 W Hwy 12 Webster, SD 57274

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure the staff educated the resident or the resident's representative of the risks versus benefits of medications or of alternative treatments to make an informed decision for the consent for the use of psychotropic medications (drugs that affect brain activities associated with mental processes and behavior) before they were administered to three of three sampled residents (1, 12, and 25). Findings include:1. Review of resident 1's electronic medical record (EMR) revealed that he was admitted to the facility on [DATE]. His 2/11/26 Brief Interview Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depression (mood disorder characterized by persistent, severe feelings of sadness, worthlessness, and a lack of interest in previously enjoyed activities for at least two weeks), anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and a psychotic disorder with delusions (false beliefs and distorted views of reality). On 2/19/26, resident 1's psychiatric provider ordered to decrease his Seroquel to 12.5 mg BID and 50mg at HS for psychosis and physically aggressive behaviors and to Start Seroquel [an antipsychotic medication] 12.5 mg [milligram] BID [twice a day] PRN [as needed] for 14 days. A 2/19/26 nurse's progress note indicated resident 1's representative was notified of the psychiatric provider's new orders for Seroquel. There was no documentation that resident 1 or his representative was informed of the indication for the medication change, the risks versus benefits of the medication, or alternative treatments to the medication. 2. Review of resident 12's EMR revealed that she was admitted to the facility on [DATE]. Her 3/16/26 BIMS assessment score was 10, which indicated her cognition was moderately impaired. Her diagnoses included Neurocognitive disorder (a decline in cognitive functions like memory, attention, and language due to brain damage) with Lewy bodies (abnormal clumps of protein that build within nerve cells) with hallucinations (to see, hear, smell, taste or touch something that is not there)/psychiatric disturbances, Auditory hallucinations, Dementia (a group of symptoms affecting memory, thinking, and social abilities), and Post-Traumatic Stress Disorder (a mental health condition triggered by experiencing or witnessing terrifying, life-threatening or traumatic events). Resident 12 had a 2/25/26 physician's order for Olanzapine (an antipsychotic) 15 mg tablet to be taken once daily by mouth. There was no documentation that indicated the staff provided information to resident 12 or her representative regarding resident 12's psychotropic medication Olanzapine. Her 2/26/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) identified a problem area: ADLs [activities of daily living] Functional Status/Rehabilitation Potential A goal stated that the Resident will remain free of adverse side effects of medications while maintaining current participation in ADL task., with an intervention of Receives psychotropic medication as directed, see eMAR [electronic medication administration record]. Monitor for effectiveness of the (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication and side effects with MD [medical doctor] updated when [they are] noted. Pharmacy reviews [resident 12's] medications monthly. Monitor for increase in behaviors, changes in overall physical ability, notify MD when [they are] noted. 3. Interview on 4/15/26 at 1:57 p.m. registered nurse (RN) manager/infection preventionist (IP) C revealed she was responsible for keeping track of the residents' psychotropic medications and contacting and updating resident representatives of residents' medications changes. She indicated she reviewed psychotropic medications when residents were admitted to the facility and when residents' medication orders were changed. She educated residents and their representatives on an individual basis with psychotropic medication changes. She indicated that informed consents regarding psychotropic medications and their risks versus benefits were obtained verbally from residents or the resident's representative, and the facility did not use a written informed consent form. 4. Review of resident 25's EMR revealed that he was admitted to the facility on [DATE]. His BIMS assessment score was 2, which indicated his cognition was severely impaired. His diagnoses included dementia with agitation and insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or waking up too early and being unable to return to sleep). Resident 25 was prescribed quetiapine (an antipsychotic medication) 12.5 mg (milligrams) to be administered at bedtime when he was admitted to the facility. On 10/24/25, a nurse's progress note indicated that the resident's representative was contacted by phone by registered nurse RN manager/IP C, and they discussed whether resident 25 should receive psychiatry services for his dementia. The resident representative agreed that resident 25 should receive psychiatry services and signed the consent forms for those services. A referral for the resident to receive psychiatry services was sent to resident 25's physician that same day (10/24/25). There was a 10/29/25 physician's order for trazodone (an antidepressant medication) 50 mg tablet to be administered at bedtime for insomnia. RN manager/IP C notified resident 25's representative, by phone, of the physician's new medication order. The progress note did not indicate that the representative gave their informed consent for resident 25 to be administered that medication or that education regarding the risks versus benefits of that medication was provided by RN manager/IP C. There was no documentation of written consent in Resident 25's EMR. There was a11/3/25 physician order for resident 25 to be administered an additional dose of quetiapine 6.25 mg, one time a day PRN (as needed) for his agitation. There was no documentation in resident 25's EMR indicating that resident 25's representative was notified and gave their informed consent for the additional antipsychotic medication, that education regarding the risks versus benefits of the medication was provided, or that written consent was obtained. There was an 11/6/25 physician's order to change the administration of resident 25's quetiapine from 12.5 mg at bedtime to 12.5 mg three times daily, discontinue the additional 6.25 mg PRN dose, and start Celexa (an antidepressant medication) at 10 mg daily for resident 25's mood disturbance. RN manager/IP C notified resident 25's representative by phone of the physician's new medication order. The progress note did not indicate that education on the risks versus benefits of the new antidepressant medication was provided, or that written consent for the changes in medication and dosage was obtained. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/8/25, a nurse's progress note indicated that resident 25's representative and family member visited and informed RN K that resident 25 was snowed [heavily sedated] and was upset about the medication changes. The family stated that the 12.5 mg dose of quetiapine being administered three times a day was like a chemical restraint and asked the physician to reduce the quetiapine to 6.25 mg twice daily. RN K contacted the physician immediately, and the physician ordered a reduction in resident 25's quetiapine to 6.25 mg twice daily. The physician also ordered an additional 6.25 mg dose to be given once daily as needed for resident 25 when increased agitation occurred. Resident 25's representative was satisfied with those medication orders. On 11/9/25, resident 25's representative called and spoke with licensed practical nurse (LPN) L, requesting that resident 25's Celexa be held and that she would visit with RN manager/IP C on 11/10/25 to discuss the request. Resident 25's representative wanted resident 25 to be off psychotropic medications and believed resident 25's behaviors were related to chronic pain. Resident 25's Celexa was discontinued by the physician on 11/13/25 at resident 25's representative's request. On 1/22/26, resident 25 received a physician order to change his quetiapine to 6.25 mg twice daily PRN for 14 days. RN manager/IP C notified resident 25's representative by phone of the new order. Resident 25's quetiapine 6.25 mg PRN medication was discontinued on 2/5/26. His 2/3/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) identified a problem area: The resident requires assistance with activities of daily living (ADLs) throughout the day to ensure his needs are met as he has a diagnosis of dementia. A goal stated that the Resident will remain free of adverse side effects of medications while maintaining current participation in ADL tasks, with an intervention of Administer medication as ordered and monitor for side effects. The 2/3/26 care plan also identified a problem area of Mood, Behavior, and Sleep with a goal to Adjust to the nursing home without increased signs and symptoms of anxiety or depression. The interventions included Nursing to follow up on all physician recommendations for medication management, Nursing will monitor for effectiveness of mood, behavior, and sleep medications and report any concerns to the provider, and if needed, A referral will be made to psychiatry for added medication management. 5. Interview on 4/15/26 at 1:57 p.m. with RN manager/IP C revealed that she was responsible for keeping track of residents' psychotropic medications, contacting residents' families, and updating residents' representatives regarding medication changes and new medication orders from physicians. The residents' medications were reviewed and the side effects were discussed with the residents and their representatives upon admission to the facility. She educated the resident or the resident's representative about the psychotropic medication(s) on an individual basis. RN manager/IP C stated that progress notes documenting medication changes, new medication orders, and family/resident representatives' notifications were recorded in the resident's EMR, but that the notes did not include specific details about the risk-versus-benefit information provided to the resident or the resident's representative regarding the resident's psychotropic medications. RN manager/IP C stated that progress notes documenting medication changes, new medication orders, and family notifications were recorded in the resident's EMR, but that the notes did not include specific details about the risk-versus-benefit information provided to the resident or the resident representative regarding the resident's psychotropic medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN manager/IP C indicated that residents who were admitted to the facility while taking psychotropic medications, or were admitted before they started a psychotropic medication, did not have written informed consent forms obtained from the resident or the resident's representatives. The informed consents were obtained verbally by staff from residents or residents' representatives. RN manager/IP C acknowledged that there was no documentation in resident 25's EMR to indicate information was provided to his representative, that written informed consent forms were obtained for every medication change, or before starting him on a new psychotropic medication, and that his care plan did not address the risks versus the benefits of the psychotropic medications. 6. Interview on 4/15/26 at 2:57 p.m. with administrator A revealed that she believed the facility's process for educating and obtaining consent from residents or resident representatives regarding the use or initiation of a psychotropic medication was adequate. She stated that RN manager/IP C was diligent in notifying families or resident representatives of residents' medication changes and new medication orders, obtaining verbal consent for the use or initiation of psychotropic medications, and documenting the information in the residents' EMR. Administrator A acknowledged that the facility did not use a written informed consent form for residents taking psychotropic medications, which outlined the risks versus benefits and alternative treatments. She was unaware that documentation of the risks versus benefits reviewed with the resident or the resident's representative should be in the resident's EMR. She expected RN manager/IP C and all nurses to discuss the risks and benefits of medications, the reason a medication was started, or any medication dose change with the resident or the resident's representative, and to document those actions in the resident's EMR. 7. Review of the provider's 2/13/26 Psychotropic Medication policy found that Psychotropic medications will only be used when medically necessary, after non-pharmacological interventions have been attempted and documented, unless contraindicated, and that All psychotropic medications require dose, frequency, duration, and a clear indication for use. Informed consent must be obtained from the resident or the responsible party, and Written consent or other documentation is acceptable. Residents have the right to be informed of treatment options, and To ensure the safe, appropriate, and clinically justified use of psychotropic medications in accordance with CMS regulations and applicable state requirements while promoting residents' rights, safety, and quality of life.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 October 2025 review, the provider failed to ensure one of one sampled residents' (1) Minimum Data Set (MDS) (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs) assessment was accurately coded for the area of PASARR, and one of one sampled residents' (12) MDS assessment was accurately coded for the area of active diagnoses. Findings include:1. Review of resident 1's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. His 2/11/26 Brief Interview of Mental Status (BIMS) assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included Alzheimer's disease (a progressive and irreversible brain disorder that affects memory, thinking, social abilities, and body functions), major depression, anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and a psychotic disorder with delusions (false beliefs and distorted views of reality). Resident 1's 4/10/25 comprehensive admission and his 11/14/25 comprehensive MDS Assessment, section A (PASRR) under Preadmission Screening and Resident Review (PASRR) section did not have the Level II PASRR at A1500 marked as a yes. Resident 1's 4/12/17 Level I PASRR review was completed when he was admitted to a different facility. That Level I PASRR was sent for a Level II determination and was approved for a long-term care stay of 30 days or less. His 5/11/17 Level II PASRR approved him for a 60-day long-term care stay, and his 7/26/17 Level II PASRR determined he was approved for a long-term-care stay for an unlimited amount of time. 2. Interview and EMR review on 4/15/26 at 2:16 p.m. with MDS coordinator D confirmed resident 1 did have a mental health diagnosis of major depressive disorder. MDS coordinator D had indicated in his MDS assessments that he did not have a Level II PASRR. She further indicated that she had made a mistake by indicating he did not have a Level II PASRR. 3. Review of the 2025 South Dakota PASRR Level 1 and Level II PASRR Outcomes instructions revealed that when a Level II PASRR was approved for a long-term-care stay, the MDS was to be completed to indicate that resident had a Level II PASRR. 4. Review of resident 12's EMR revealed she was admitted to the facility on [DATE] and had a diagnosis of post-traumatic stress disorder (PTSD). Her 3/4/26 admission MDS Assessment, section I (active diagnoses) under Psychiatric/Mood Disorder did not have the diagnosis I6100 Post Traumatic Stress Disorder marked. 5. Interview and EMR review on 4/15/26 at 2:39 p.m. with MDS Coordinator D revealed she acknowledged that resident 12 had a diagnosis of PTSD upon admission to the facility on 2/25/26. She confirmed resident 12 had received psychiatric services before she was admitted to the facility, and that resident 12 received psychiatric services on 3/26/26 with a new provider. She reviewed resident 12's admission MDS assessment, section I and acknowledged that I1600 Post Traumatic Stress Disorder was not marked. When completing the resident's MDS assessment she referred to the resident's information that was sent with them to the facility when they were admitted , which included diagnosis, medication order's and physician progress notes. She did not consider resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12's PTSD an active diagnosis since the resident did not have any medications prescribed for PTSD. She referenced the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 to complete the residents' MDS assessments. 6. Review of the CMS Long-Term Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed review of the CMS Long-Term Care Facility RAI 3.0 User's Manual Version 1.20.1 October 2025 revealed section A, item A1500 revealed Code 1, yes if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD [intellectual disability/developmental disability] or related condition. Section I, Page I1 and I2, Steps for Assessment: 1. Indicate the resident's primary medical condition category that best describes the primary reason for the Medicare Part A stay. Medical record sources for physician diagnoses include the most recent history and physical, transfer documents, discharge summaries, progress notes, and other resources as available.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, policy review, and review of budesonide (a steroid used to treat lung inflammation) manufacturer's instructions the provider failed to ensure staff administered the budesonide nebulizer (a device that converts liquid medication into an inhalable mist) according to the manufacturer's instructions for one of one sampled resident (7) who developed thrush (a yeast infection in the mouth and throat). Findings include:1. Observation on 4/13/26 at 2:44 p.m. of resident 7's room revealed there was a nebulizer machine and mask on his bedside table between his bed and recliner. The nebulizer mask was assembled and sitting on the nebulizer machine. 2. Observation and interview on 4/14/26 at 8:29 a.m. with resident 7 in his room revealed he was admitted to the facility after he was in the hospital for shortness of breath. The nurses and certified medication aides (CMAs) administered a nebulizer treatment to him two times a day, once in the morning and once at bedtime. The nurse or CMA would set up his nebulizer and often left the room while he was taking the nebulizer treatment. Sometimes the nurse or CMA returned to his room and rinsed out the nebulizer mask, sometimes they did not. When he finished with his treatment he would place the nebulizer mask on top of the nebulizer machine, which was on his bedside table. The medication chamber attached to the nebulizer mask appeared hazy with an unknown substance.The staff did not ask him to rinse out his mouth after he received his nebulizer treatments and he did not know he should rinse out his mouth after his nebulizer treatments. He knew one of his nebulizer medications caused him to get thrush sometimes, and he would take a lozenge (a medicated tablet to be held in the mouth to dissolve) to treat it. 3. Review of resident 7's electronic medical record (EMR) revealed he was admitted to the facility on [DATE], had a 1/30/26 Brief Interview for Mental Status (BIMS) assessment score of 12, which indicated his cognition was moderately impaired, and his diagnoses included chronic obstructive pulmonary disease (a group of lung diseases that block airflow and can make it difficult to breathe) (COPD). His 4/14/26 care plan indicated he had his own teeth and to assist with oral cares in am [a.m.] and pm. [p.m.].He had a 10/13/25 physician's order for clotrimazole troches (a medication to treat thrush) lozenge 10 milligrams (mg) one time a day at bedtime for thrush and a 11/5/25 physician's order for a budesonide nebulizer 0.5 mg/ 2 ml (milliliters) two times a day with instructions that stated, Make sure mouth is being rinsed with water after to help prevent oral thrush.On 10/30/25 resident 7's physician was notified by registered nurse (RN) M that resident 7 was requesting that he get 5 clotrimazole troches every day because he feels like he has oral thrush. No white spots noted in [his] mouth but [the] resident states that he has had it twice before and ?this is exactly what it was before when I had it'. On 10/30/25 Resident 7's physician ordered clotrimazole troche five times per day for two weeks for thrush. 4. Interview on 4/15/26 at 10:58 a.m. with RN G revealed when she administered a resident's nebulizer she would set up the nebulizer treatment, remained in the room with the resident, and when the treatment was completed, she shook out the excess liquid from the nebulizer medication chamber and placed the mask in a vented storage bag to dry. A resident who received steroid medications such as budesonide should be encouraged to rinse their mouth after that nebulizer treatment. 5. Interview on 4/15/26 at 4:23 p.m. with director of nursing (DON) B and RN manager/infection preventionist (IP) C revealed DON B expected that after a resident's nebulizer was completed, the nebulizer mask would be rinsed out. RN manager/IP C corrected DON B and stated the provider's policy had changed and any excess liquid from the nebulizer treatment was to be shaken out of the nebulizer medication chamber and the nebulizer mask was to be placed in a vented storage bag to dry.DON B expected a resident's mouth to be rinsed if the nebulizer treatment was a steroid such as budesonide and if the nebulizer mask was soiled it was to be rinsed out with distilled water. She was not aware the budesonide nebulizer manufacturer's instructions were to wash the nebulizer mask with a mild detergent after each administration of the medication. 6. Review of the provider's 8/11/23 Nebulizer Administration policy (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that if the resident's nebulizer is to be reused, discard any excess solution and place in vented storage bag and if residue is noted, discard nebulizer and replace with new or rinse with sterile water and allow to air dry in a vented bag. Do not rinse with tap water. 7. Review of the 2/13/23 budesonide manufacturer's instructions revealed the incidence of candidiasis [yeast infection] can generally be held to a minimum by having patients rinse their mouths out with water after each nebulization treatment. The nebulizer chamber should be cleaned after every administration. Wash the nebulizer chamber and mouthpiece of face mask with hot tap water using a mild detergent. Rinse it well and dry by connecting the nebulizer chamber to the compressor or air inlet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, observation, interview, and policy review the provider failed to ensure drugs and biologicals were labeled, securely stored, and discarded regarding:*One of one fentanyl patch (a medications with risk for abuse and addiction) pain medication for resident 35 that was not administered or securely stored after it was removed from the double locked storage on medication cart C by registered nurse (RN) K.*One of one sampled resident's (24) Vicks Vaporub, Gold Bond Medicated Powder, Blu-Emu Cream (a pain-relieving cream) Voltaren 1% cream (a pain-relieving cream), and seawater nasal spray that were not securely stored to prevent other residents from accessing them.*Medications with shortened expiration dates (medications that, after opening, expire before the manufacturer's expiration date) that were not labeled and disposed of after being outdated for two of two sampled residents (13 and 18), latanoprost eye drops in two of three observed medication carts.*Expired insulin syringes that were not disposed of and available for use in three of three observed medication carts and one of one observed medication room. Findings include:1. Review of the provider's [DATE] SD DOH FRI revealed that director of nursing (DON) B was notified by RN K that there was a missing (not accounted for) fentanyl patch at 9:05 a.m. on [DATE]. RN K stated she placed the fentanyl patch on top of a Tegaderm (clear adhesive dressing) to carry into resident 35's room, and when she was going to place the fentanyl patch on resident 35, she did not have the fentanyl patch. RN K reported to DON B that she had searched resident 35's room including the resident's chair, the garbage can next to her chair, and the floor. RN K then went back into the hallway, looked on the floor in the hallway, checked the bottom of her shoes, and the garbage can on the medication cart, and RN K was unable to find the fentanyl patch.After director of nursing (DON) B was notified of the missing fentanyl patch, she notified additional staff members to assist in looking for the missing fentanyl patch. Those staff members looked in the laundry room including the washer, dryer, lint traps, and the dirty laundry from hallway C. The drawers were removed from medication cart C. Housekeeping staff searched the hallway, resident 35's room, and the vacuum. Maintenance took the vacuum apart to be sure the fentanyl patch was not in a vacuum hose.DON B asked RN K if she had the fentanyl patch in her hands when she went into resident 35's room and RN K stated she thought she did. She had taken the patch out of the locked controlled substance drawer in medication cart C, wrote her name and initials on the fentanyl patch, and laid it on the Tegaderm package. She then picked up the Tegaderm, fentanyl patch, resident 35's other medications, and her Voltaren cream, brought them into resident 35's room and placed them on her bedside table. When RN K was going to place the fentanyl patch on resident 35 RN K noticed she had written on the plastic piece that was attached to the adhesive part of the fentanyl patch, and that the patch was not there.RN K stated she had gone into medication cart C, taken out another fentanyl patch, and placed it on resident 35. DON B asked RN K why she did not notify her or one of the other managers of the missing fentanyl patch before 9:05 a.m., and RN K stated she was waiting until DON B arrived at the facility to notify her.When DON B looked through the garbage, all the packaging pieces for one of the fentanyl patches were found, but only a small piece of packaging from the top and the side of the other fentanyl patch was found in the garbage. The piece that RN K stated she had written her name and date on was not found.DON B, RN Manager/infection preventionist (IP) C, and RN/staff development coordinator (SDC) H watched the facility's [DATE] camera footage to determine a timeline and to assist in the search for the missing fentanyl patch. Medication cart C was placed between two resident rooms in hallway C. At 6:35 a.m. RN K unlocked and opened the controlled medication drawer in medication cart C and removed a fentanyl patch from that drawer. At 6:37 a.m. RN K entered resident 7's room, and exited that room at 6:39 a.m. RN K stood (continued on next page)

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	435071	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda Home	129 W Hwy 12 Webster, SD 57274

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