STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	1001 S Egan Ave Madison, SD 57042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and policy review, the provider failed to ensure a resident's right to a sense of dignity and respect was maintained by failing to promptly serve residents' meals for one of two observed meal services.Findings include: 1. Interview on 7/15/25 at 3:17 p.m. with resident 26, the resident council president, revealed: *She felt there was a problem with residents waiting a long time to have their food served. *She stated, “We wait an hour to eat, and that happens a lot.” *She stated that other residents had expressed the same concern. -Residents came to speak with her individually because many of them did not like to speak in front of a large group. -She did not say if she had brought those concerns to the dietary manager or administrator. Review of the resident council minutes from the past three months revealed no comments or notes about excessive wait times at meals. 2. Observation in the main dining room of the 7/15/25 evening meal revealed: *At 5:05 p.m. residents were entering the main dining room for the evening meal scheduled to be served between 5:00 p.m. and 6:30 p.m. -Resident 12 was assisted into the dining room by a staff member and seated at a table. -There were no water glasses or beverages on the table. *At 5:19 p.m. resident 46 entered the dining room assisted by a staff member to sit with resident 12 at her dining table. *There were seven staff members observed in the dining room. *At 5:21 p.m., the staff members began to take resident’s food orders and deliver meal trays. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*At 5:58 p.m., residents 12 and 46 were heard conversing, saying, Good [NAME], they haven't eaten either, while they looked around the dining room and remarked, Something needs done around here . -Both residents stated that they had been waiting a long time, .at least 30 minutes. *At 6:02 p.m., resident 12 and resident 46 stood up and started to walk away from the table. *At 6:03 p.m., dietary aide (DA) DD approached residents 12 and 46, asked them to sit back down at their table and stated, I haven't even given you ladies food yet. *At 6:06 p.m., DA DD served residents at another table and stated, I'm sorry it's going so slow. *At 6:07 p.m., DA DD encouraged resident 12 to sit down again and stated, It's been a while, but I'll get you some food.” DA DD then asked residents 12 and 46 what they wanted for their meals. -Resident 46 stated to DA DD I'm not hungry, but DA DD encouraged her to order some food. She chose the hoagie sandwich meal option. *At 6:11 p.m. DA DD served resident 12 a hoagie sandwich and broccoli and she began to eat her meal. -She waited 66 minutes for her meal to be served. *Resident 46, who had not been served her meal, reached towards resident 12's plate of food. -Resident 12 stated to her, It's yours, take it, but resident 46 did not take any food items. *At 6:13 p.m. DA DD served resident 46 a chef salad and a glass of water. -She waited 54 minutes for her meal to be served. *Interview at that time with resident 46 about her meal revealed she stated the meal was good. When asked if she had to wait a while for her meal to be served, she replied Yeah, I know in a disgusted tone. 3. Observation on 7/15/2025 at 5:03 p.m. of the table closest to the serving window in the assisted section of the dining room revealed: *Residents 15 and 22 were seated at the assist table, waiting for their meals to be served. *Resident 15 was seated at the table in front of a white adjustable tray and was served a glass of juice at 5:10 p.m. -She received her meal and remaining drinks at 5:33 p.m. -She waited 30 minutes to receive her meal. *Resident 22 received his meal and drinks at 5:26 p.m. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He waited 23 minutes to receive his meal. 4. Observation on 7/15/25 at 5:03 p.m. of the table closest to the handwashing sink in the assisted section of the dining room revealed: *Residents 4 and 11 were seated at the table. -Resident 4 had been served his meal and drinks and was feeding himself. -Resident 11 was waiting to be served her meal. Her meal and drinks were served at 5:36 p.m. *Resident 47 was assisted to the table and seated in front of a white adjustable tray at 5:14 p.m., and her meal was served at 5:37 p.m. -She waited 23 minutes to receive her meal. -She struggled to pick up the cut pieces of the sandwich. Paid feeding assistant GG assisted resident 47 with eating her yogurt, but did not assist or offer to help her with the sandwich. *Paid feeding assistant GG sat at the table with the residents and provided physical assistance and verbal cueing to residents 4, 11, and 47 until 6:08 p.m., when they finished eating. 5. Observation on 7/15/25 at 5:05 p.m. in the assisted dining section of the dining room revealed: *Resident 35 was seated at a table the assisted dining section at 5:06 p.m. She was not served her meal until 5:24 p.m. *Resident 36 was seated at her table at 5:09 p.m. Her meal was placed in front of her around 5:35, which was 26 minutes after she arrived in the dining room. No one assisted her to eat until 5:44 p.m. Her meal sat in front of her, untouched, for 9 minutes. *Resident 7 was seated at her table at 5:10 p.m. Her meal was placed in front of her at 5:37 p.m., which was 27 minutes after she arrived in the dining room No one assisted her to eat until 5:44 p.m. Her meal sat in front of her, untouched for 7 minutes. Review of resident 7’s and resident 36’s electronic medical record (EMR) revealed that they required full assistance from staff to eat. 6. Interview on 7/17/25 at 11:14 a.m. with DA DD revealed: *There was no order to which resident was served first in the dining room. *He said the dietary aides served whoever came to the dining room first. *The residents with diabetes were a priority to get their food first. *The dietary aides tried to spread out around the dining room with a goal of shortening the wait time for residents to be served their meals. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Interview on 7/17/25 at 11:39 a.m. with dietary manager D revealed: *She conducted her own dining observation at supper on 7/16/25 and confirmed that several residents waited “for a long time” for their meal. -She confirmed some residents waited an hour for their meals. *She was unsure of a solution due to the “bottleneck” and slowing down at the service window since there was only one person who plated the meals. 8. Interview on 7/17/25 at 1:54 p.m. with registered dietitian EE revealed: *She indicated that ideally, the residents should be served their meal “as soon as the resident arrives to the dining room.” *She estimated that a reasonable amount of time for residents to wait would be 30 minutes. *With the open dining concept, lunch and supper were difficult meals as all residents would arrive to the dining room in a short period of time. *She described the “bottleneck” slow down at the service window was because they only had one person plating the meals. *She indicated that it was “incredibly unusual” for residents to wait over an hour to be served their meals. 9. Review of the provider’s 2/18/25 The Dining Experience policy revealed: *Policy: “The goals of the dining experience is to enhance the individuals[‘] quality of life through person centered dining: providing person centered care and attention: nourishing, palatable, and attractive meals that meet the individuals[‘] daily nutritional and special dietary needs.” *Procedure: -“1. Staff will work with each person as an individual to meet their personal needs. Everyone will be treated with dignity and respect…” -“…5. Individuals at the same table will be served at the same time to the best of staff availability. ”

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F 0576 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure residents have reasonable access to and privacy in their use of communication methods. Based on interview, the provider failed to ensure the residents' right was maintained to have their mail delivered to all residents on Saturdays. The resident census was 52.Findings include: Interview on 7/17/25 at 2:18 p.m. with activities coordinator K revealed:*She did not think that the mail was delivered on the weekend. *The activities staff typically delivered mail during the week. *She was unsure whether mail was delivered to the facility on Saturdays.Interview on 7/17/25 at 2:43 p.m. with business manager P revealed: *Mail was delivered to the facility on Saturdays. *She stated that administrative assistant Q delivered Saturday's mail to the residents on Monday mornings.*Mail that was delivered to the facility on Monday was given to residents later that same day.Interview on 7/17/25 at 3:11 p.m. with administrator A revealed: *The activities staff usually delivered the mail during the week. *He was unaware that mail was required to be delivered to residents within 24 hours of delivery to the facility by the post office.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure accurate documentation of the resident's wishes involving their advance directives/code status for one of one sampled resident (5).Findings include:1. Record review of the medical record for resident 5 revealed:*She was admitted on [DATE].*Her Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated she had moderate cognitive impairment.*The CPR (cardiopulmonary resuscitation, an emergency procedure to provide chest compression and often rescue breathing to preserve brain function and maintain blood circulation) Statement of Decision indicated the resident wanted CPR.*Her advance directive (a legal document that expresses a person's health care wishes if they become unable to speak for themselves) indicated she did not want CPR, signed on [DATE]. 2. Interview and medical record review on [DATE] at 9:26 a.m. with registered nurse (RN) H about resident 5 revealed:*Resident 5's CPR status in the paper medical record stated I do wish CPR to be initiated, signed by her power of attorney (someone designated on a legal document to act on resident's behalf) and her doctor on [DATE].*RN H stated the form was reviewed quarterly (every three months) at every care conference with the family.*Her CPR status was listed as do not resuscitate (DNR) in the electronic medical record (EMR).*Her doctor ordered her status as DNR in the EMR on [DATE]. 3. Interview and medical record review on [DATE] at 3:45 p.m. with RN CC about resident 5 revealed:*If she needed to verify a resident's CPR status to determine if she was to provide CPR or withhold it, she would look at the resident's paper chart.*She looked at the CPR Statement of Decision form in resident 5's paper chart and indicated the resident would want CPR. She stated she thought that was incorrect, looked at Resident 5's EMR, and stated she was listed as a DNR there. The DNR order was ordered on [DATE] by her doctor.*She verified that resident 5's South Dakota Advance Directive, located in her paper chart and signed by the resident on [DATE], indicated she did not want her life prolonged but to be kept comfortable.*She checked the white dry-erase board in the report room, which listed any resident who wanted CPR. Resident 5 was not listed.*She stated she would notify the social worker, obtain a new form for the resident's family to sign, and then send it to the doctor to be signed.*She stated she would keep the incorrect form in the resident's chart until the new form was completed, unless the social worker directed otherwise.*She stated there were no electronic copies of the CPR Statement of Decision form, and the paper copy was to be kept in her chart. 4. Interview on [DATE] at 3:50 p.m. with the director of nursing (DON) B about resident 5 revealed she expected the resident's code status in the EMR and paper charts to match. 5. Review of the provider's undated Advance Directive Information policy revealed:*The provider is required by Federal Law.It is the policy of [the provider] to respect autonomy [personal choice]. Advance Directives, including the living will and durable power of attorney for healthcare, will be honored. 6. Review of the provider's handout that was untitled about Resident Rights and advance directives stated: The Resident has a right to formulate advance directives. It is the responsibility of the Resident to timely provide the Facility with copies of the Resident's advance directive for reference and incorporation into the Resident's medical record.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure one of one sampled resident (3) who was at risk of developing a pressure ulcer did not develop a new pressure ulcer.Findings include: 1. Observation on 7/15/25 at 8:45 a.m. of resident 3 in her room revealed she was resting in her recliner with her feet elevated and had blue heel protector boots [padded to relieve pressure] on. 2. Interview on 7/15/25 at 10:34 a.m. with infection preventionist C revealed that resident 3 was receiving wound care for a pressure ulcer. 3. Review of resident 3's electronic medical record (EMR) revealed:*She was admitted on [DATE] after a fall that resulted in a broken hip, which required surgical repair.*She had a 4/3/25 Brief Interview for Mental Status (BIMS) assessment score of 3, which indicated she had severe cognitive impairment.*A 4/15/25 initiated care plan intervention area indicated the need for Weekly skin assessment by a licensed nurse.*A 4/15/25 initiated care plan intervention area indicated that staff were to Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.*A 4/15/25 initiated care plan intervention area indicated staff were to Follow facility policies/protocols for the prevention/treatment of skin breakdown.*A 4/20/25 skin/wound note indicated a Circular purple area noted to left heel. Area measures 2.8cm [centimeter] X [by] 2.0cm. Area tender upon light palpation. Heel protectors placed to bilat [bilateral] feet at all times. [Provider] updated via fax. [Son] updated via phone.*A 4/20/25 initiated care plan intervention area indicated the resident was To wear blue suspension air/foam boots to bilat [bilateral] feet at all times. May remove for transfers.*A 4/23/25 initiated care plan intervention area indicated that she required substantial/maximal assistance (staff provides more than half the effort required for a task) by one to two staff with bed mobility, including rolling side to side, and moving between lying and sitting positions.-Staff were to assist her with repositioning routinely and as needed in both bed and a chair. *A 4/23/25 initiated care plan intervention area indicated that she required substantial/maximal to total assistance of one to two staff members while using a lift to assist for transfers.*A 4/24/25 Skin & Wound Evaluation indicated:-This wound was a pressure ulcer.-The stage of this wound was categorized as Deep Tissue Injury: Persistent non-blanchable deep red, maroon or purple discoloration.-This wound was assessed as In-House Acquired and not present on admission.-The wound had been present from the exact date of 4/20/25 and it was 1.8 centimeters long by 1.8 centimeters wide.--The previous skin assessment indicated no new skin concerns. 4. Observation on 7/15/25 at 2:56 p.m. of resident 3 in her room revealed she was sleeping in her recliner with her feet elevated and had blue heel protector boots on. 5. Interview on 7/16/25 at 10:02 a.m. with resident 3 in her room revealed:*She had no concerns with the care she was receiving.*She stated she had no problems with her skin except on the one leg that broke. 6. Observation on 7/16/25 at 1:16 p.m. of registered nurse (RN) H while providing resident 3's wound care revealed:*She stated the treatment order directed to use Medi Honey (a wound healing product) on the pressure ulcer, but the facility was out of the product. The pharmacy was having difficulty obtaining it, and an alternate supplier had to be used to obtain the Medi Honey. Delivery was expected the following Monday.*RN H used appropriate personal protective equipment (PPE), including a gown and gloves, a clean barrier, and demonstrated proper hand hygiene throughout the wound care procedure.*She then placed the Ace wrap (elastic bandage wrap) and heel protector boot back on the resident. 7. Interview on 7/16/25 at 2:41 p.m. with RN H revealed:*She was unaware that the Medi Honey was not available until she was gathering supplies to provide the wound care.*She notified the resident's primary care provider that the Medi Honey was unavailable via fax that day. *She stated the pressure ulcer was healing well.*She confirmed the pressure ulcer developed after the resident was admitted to the facility (facility-acquired).*She stated she provided education about skin and wound care to staff during the facility's annual skills lab.-Topics covered include appropriate skin care, proper resident positioning, repositioning every two hours, and using pillows to prop and support residents.*She had recently been educating certified nursing assistants (CNAs) about floating heels (elevating the heels to prevent pressure from contact with surfaces) when heel protector boots are not well tolerated. 8. Interview on 7/16/25 at 2:52 p.m. with CNAs V and U about preventing pressure ulcers revealed they would:*Prevent pressure ulcers by repositioning residents at least every two hours.*Use barrier cream to protect residents' skin from breakdown.*Ambulate residents if residents were able.*Encourage residents' participation in activities.*They stated most residents have wheelchair cushions and some use air mattresses (both used to

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the provider failed to provide range of motion (measurement of movement around a joint or body part) (ROM) exercises for two of two residents (26 and 36) in an attempt to prevent a decline (worsening in physical status) in ROM.Findings include: 1. Observation and interview on 7/15/25 at 3:40 p.m. with resident 26 revealed she:*Was lying in bed and had some deformity to her fingers. She indicated she had arthritis.*Was alert and capable of making her needs known.*Participated in a restorative program Whenever I can get in and indicated that occurred approximately twice per week. *Wanted to have restorative programming more than she was, because she felt the more she moved around, the less pain she had.*Indicated she does not wear any type of splints or devices to help with stretching, preventing further ROM decline in her hands. 2. Interview on 7/17/25 at 9:56 a.m. with certified nursing assistant (CNA)/restorative aide Z regarding restorative exercises revealed:*She tried to do restorative exercises with resident 26 at least twice a week.*She stated it was hard to get everyone in for restorative exercises more than twice a week because she was the only restorative aide and there were a lot of residents on a restorative program.*Sometimes it was hard to get resident 26 in for exercises when her daughter visited.*Another restorative aide was to start next week to help her.*She stated the goal for resident 26 was to maintain her current ROM function.-Her ROM had improved since she admitted to the facility. 3. Continued interview on 7/17/25 at 10:00 a.m. with CNA/restorative aide Z about resident 36 revealed:*The resident had started to decline, and her passive (movement to the area is provided by someone else) ROM was getting worse.*Her joints had started to contract (muscles, tendons, or skin tighten and shorten, leading to a reduced range of motion).*She had tried to massage the resident in addition to providing passive ROM (PROM) exercises.*CNAs did not provide ROM. She stated, Just restorative does it.-Leadership had been considering having the CNAs start to assist with PROM exercises.*She tried to see the resident at least twice a week or more because her ROM had started to decline and her muscles were getting tighter. *She reported that the resident had shown nonverbal cues of pain during ROM exercises sometimes. 4. Interview on 7/17/25 at 11:05 a.m. and again at 1:41 p.m. with restorative registered nurse (RN) F regarding restorative exercise programming revealed:*CNAs do not perform ROM exercises while working on the floor assisting residents with care needs, but they were looking into having them do it.*Resident 36's right leg ROM has been worsening over the past two months.*Every resident on admission was to be assessed for restorative needs and a restorative plan.*Resident 36 had been independent with transfers on admission.-As of 7/17/25, she was dependent on staff with transfers using a mechanical lift (a mechanical device used to assist with transfers). *Resident 36 was admitted on [DATE], and since then she had:-Lost the ability to walk and transfer herself.-Decreased ROM and limitations to her shoulders, elbows, and knees. *She stated resident 36 currently had stiff joints in both of her knees, shoulders, and elbows. Her right hip had progressed to where it has crossed over the left leg.*Resident 36 had been placed on the restorative program after the resident started to develop contractures.*She stated they talk about residents 36's restorative program at every care conference.*She expected the resident to have had ROM as much as the restorative aide could do it in a week, but at least a few times per week.*She stated another restorative aide was starting next week, so residents could be seen more.*She was unsure how often ROM should have been completed to help prevent contractures.*Resident 36 had been on hospice from 11/16/24 to 4/29/25. She was unsure if hospice provided ROM exercises, in addition to the provider's restorative program, during their visits.*She stated Resident 36's hands were tight, but she did not have any hand devices in place to help with the stretching or prevention of contractures.-She has been able to get her hands to relax during PROM exercises. 5. Interview on 7/17/25 at 2:05 p.m. with restorative nurse F about restorative programing and resident 26 revealed she:*Would have expected the resident to have restorative exercises done a few times per week.-She did not state what she considered a few times a week was.*Stated resident 26 completed exercises in her room on her own in addition to the restorative program.*Reported that resident 26's weakness varies day by day.*Stated that resident 26 did not use any devices to prevent further ROM limitations and contractures.*Stated she completed ROM assessments with each resident's Minimum Data Set (MDS) assessment (a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs).*Felt the CNA/restorative aide would have notified her if there were any changes to the resident's strength. 6. Observation on 7/17/25 at 2:12 p.m. of resident 36

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to follow food safety standards by having failed to: *Maintain a sanitary kitchen environment in one of one kitchen.*Discard expired foods (spinach and white icing) in one of one walk-in cooler and one of one dry storage area.*Store perishable foods (sweet cream butter) at the appropriate temperatures.*Practice safe food handling with glove use by one of one dietary aide (R).*Practice appropriate hand hygiene (washing hands or using hand sanitizer) while assisting residents to eat by one of two paid feeding assistants (GG).*Practice appropriate hand hygiene with glove use by one of one cook (HH).Findings include: 1. Observations on 7/15/25 from 8:31 a.m. to 9:35 a.m. during the initial kitchen tour revealed: *The tea dispenser in the beverage preparation area was visibly soiled. -The spout had a buildup of sticky brown residue, the bag of tea concentrate inside the machine was starting to deposit clumps of dried tea on the inside of the bag, and the tubing connecting the tea bag to the spout was visibly soiled on the inside of the clear tube. -There was a layer of dust on top of the machine. -There was a sticker on the inside of the machine that read, “IMPORTANT – PERFORM CLEANING EVERY OTHER DAY. -The bag of tea was not dated to indicate when it had been hooked up to the tea dispenser. *The filter on the side of the water and ice dispenser machine was covered with dust. *The cabinetry was made of wooden particle board. -The cabinet space under the sink had visible signs of water damage. -The boards were warped, had water stains on them, and there were black specks throughout the cabinet space that appeared to have been mold. *In the dish washing room: -The paint was peeling away from the walls. The exposed drywall appeared to have water damage. -The wall-mounted fan had a layer of dust on it. The fan was pointed directly at the clean dish area. -The garbage disposal was disconnected from the sink. In place of the disposal, an old white food bucket (one that may have contained food such as peanut butter, ice cream, coleslaw, etc.) was installed in its place as a makeshift sink basin. That food bucket was in poor condition. *Inside the dishwasher: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	1001 S Egan Ave Madison, SD 57042

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The upper wash arm had lint stuck in one of the spray nozzles. -There was a thick layer of wet soap scum and food particles caked to the upper inside of the dishwasher doors. *In the main kitchen, the cabinetry was also made from wooden particle board. -The cabinet spaces under the various sinks were in the same deteriorated and moldy condition as the cabinets in the beverage preparation area. -There was visible water damage in the cabinet that contained the water heater. -Other cabinet spaces were lined with white plastic sheeting. --There was a buildup of a brown sticky substance throughout the cabinet and drawer spaces. --Those cabinets and drawers stored food preparation equipment that included colanders, pots, pans, mixing spoons, spatulas, among other tools. *There was a stainless-steel food prep table to the left of the walk-in cooler. The drawers in that table contained serving scoops. There was an abundance of food crumbs and dust in the drawers. *There were at least four bags of spinach in the walk-in cooler that were visibly wilting and had a collection of brown and white liquid in the bags. -The delivery label indicated those bags of spinach had been delivered on 6/19/25, which was 26 days prior to the survey entrance. *There was an unlabeled and undated container of what appeared to have been butter sitting on the counter at room temperature. -There were two, one-pound bricks of sweet cream butter sitting behind that container. They were soft to the touch as if they had been sitting out at room temperature for a few hours. The manufacturer’s label read, “PERISHABLE KEEP REFRIGERATED.” *The drywall behind the reach-in cooler was deteriorating and crumbling on the floor. *There was a bucket of “White Dipping Icing” in the dry storage area with “6-14” handwritten on the side of the bucket. -There was an unclearly handwritten opened date that read either “Open 7-26-24” or “Open 9-26-24.” -The manufacturer’s sticker on the side of the bucket read, “USE BY 02 [DATE].” 2. Interview on 7/15/25 during the initial kitchen tour at 9:25 a.m. with dietary aide R and cook Y revealed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*One of their coworkers had recently cleaned the walk-in cooler and missed the spoiled spinach. *They could not remember when spinach was last on the menu. -When reviewing the menu, it was discovered that there was supposed to have been a spinach side salad that night for supper. 3. Interview on 7/15/25 during the initial kitchen tour at 9:35 a.m. with dietary manager D revealed that she had started her position as the dietary manager about three weeks ago. 4. Observation on 7/15/25 at 11:13 a.m. of dietary aide R in the dining room revealed:*She was plating and serving meals from the serving window. *She was wearing gloves and used her gloved hands to touch multiple surfaces and utensils, including plates and tongs, and then directly touched ready-to-eat food items (dinner rolls).*At 11:19 a.m., she continued to use the same gloved hands to touch multiple surfaces and then handled ready-to-eat foods (dinner rolls) without changing gloves or performing hand hygiene.*At 11:28 a.m., she was observed to continue that same pattern of touching multiple items with those same gloved hands and then handling ready-to-eat foods.*At 11:36 a.m., she again touched various items with those same gloved hands and handled a ready-to-eat bun.*At 11:42 a.m., she wiped her face with the back of her left gloved hand and then resumed plating meals without changing gloves or washing her hands. Interview on 7/17/25 at 12:12 p.m. with infection preventionist (IP) C revealed the above observations did not meet her expectation of appropriate hand hygiene. 5. Observation on 7/15/25 of the assisted section of the dining room revealed: *At 5:50 p.m., paid feeding assistant GG sat between residents 11 and 47 at assist table #2, helping them eat. -Using her right hand, paid feeding assistant GG started rubbing resident 11’s right shoulder to wake her up so she would eat. -Without performing hand hygiene, paid feeding assistant GG picked up resident 47’s spoon (with her right hand) and fed her a bite of yogurt. *At 5:55 p.m., feeding assistant GG took off the clothing protector from resident 47 and washed her face and hands with a wet washcloth. *Without performing hand hygiene, she returned to resident 11, sat down, picked up her glass, and helped her with a sip of her Ensure protein drink. *At 5:58 p.m., paid feeding assistant GG assisted resident 47 out of the dining room by pushing her wheelchair. *At 6:00 p.m., she returned to the table, did not perform hand hygiene, picked up resident 11’s spoon, and offered her a bite while rubbing the resident’s right shoulder. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*At 6:05 p.m., paid feeding assistant GG stood and approached resident 4 at the table, did not perform hand hygiene, and picked up his spoon and fed him a bite. *She returned to resident 11, did not perform hand hygiene, removed her clothing protector, washed the resident’s face and hands, adjusted the resident’s lap blanket, and helped her out of the dining room by pushing her wheelchair. *At 6:08 p.m., paid feeding assistant GG returned to the table, did not perform hand hygiene, removed the resident’s dirty dishes, approached resident 35 at another table, placed her hand on resident 35’s back, picked up her spoon, and gave it to her. *At 6:12 p.m., without performing hand hygiene before, paid feeding assistant GG washed resident 4’s face and hands, removed his clothing protector, and helped him out of the dining room by pushing his wheelchair. *Paid feeding assistant GG did not perform hand hygiene between assisting residents after direct resident contact multiple times during meal assistance. *No glove use was observed during the meal service by paid feeding assistant GG. 6. Interview on 7/16/25 at 2:47 p.m. with dietary manager D revealed that she was aware of the issues that needed to be addressed, such as the deteriorating cabinets, the peeling paint, and crumbling drywall. She said she had discussed the necessary renovations with administrator A to make him aware of the situation. 7. Interview on 7/17/25 at 9:58 a.m. with cook HH revealed: *They deep cleaned the kitchen every two months. *It had been about two months since the kitchen was last cleaned. 8. Interview and observation on 7/17/25 at 10:07 a.m. with dietary aide II revealed: *The dishwasher was to be drained and rinsed every night. *They delimed the dishwasher once per week. *He was not aware of the grime buildup inside the dishwasher doors. 9. Observation and interview on 7/17/25 at 10:23 a.m. with cook HH revealed: *He was using the robot coupe (a type of food blender) to make mechanically altered food. *He was using his key to press in the safety button on the robot coupe. -He explained that the robot coupe had broken some time ago but would still work if the button was manually pressed and held there. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. Interview on 7/17/25 at 10:26 a.m. with dietary aide R and cook HH revealed: *In the approximately two years dietary aide R had been working there, she had always stored the butter on the counter. -She was not aware that the manufacturer’s label read, “Perishable, Keep Refrigerated.” *Cook HH said that the butter is kept at room temperature on the counter for it to be spreadable. They only used that butter for buttered toast. *He was aware that the manufacturer’s label read, “Perishable, Keep Refrigerated.” 11. Observation on 7/17/25 from 10:53 a.m. to 11:07 a.m. of cook HH serving lunch in the kitchen revealed: *At the beginning of the meal service, he put on a pair of gloves without performing hand hygiene first. *After he dished to-go orders, he changed his gloves and did not perform hand hygiene before putting on a new pair of gloves. *At 11:02 a.m., he took off those gloves to write on a piece of paper, put his pen back in his pants pocket, and without performing hand hygiene, put on a new pair of gloves. 12. Interview on 7/17/25 at 11:24 a.m. with dietary manager D revealed: *She confirmed she was aware of the deteriorating cabinetry, the drywall, and the garbage disposal. *She expected staff to perform hand hygiene before putting on gloves, when switching tasks, and after taking gloves off. *That week was her second or third week as the dietary manager and was aware that there were necessary improvements to make. 13. Review of the provider’s January 2024 Glove Use When Preparing/Serving Food revealed: *Policy: “Bare hand contact with ready to eat food is prohibited.” *“Gloves must be worn when handling ready to eat food directly. Tongs/Utensils may be used instead of gloves when serving/preparing ready to eat foods. *“Gloves may become contaminated and/or soiled and must be changed between tasks.” *“Disposable gloves are single-use items and shall be discarded after each use. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*“Hands should be washed (following Bethel hand washing policy), before gloves are put on.” 14. Review of the provider’s January 2024 Food Handling – Preventing Foodborne Illness policy revealed: *Policy: “Food will be stored, prepared, handled and served so that the risk of food borne illness is minimized.” *“Critical factors implicated in food borne illness are: Poor personal hygiene of dietary staff; inadequate cooking and improper holding temperatures; contaminated equipment; and unsafe food sources. *“All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing food borne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. *…“All food service equipment and all utensils will be sanitized according to manufacturer’s recommendations. 15. Review of the provider’s 2/18/25 Food Storage policy revealed: *Policy: “Sufficient storage facilities are provided to keep foods safe and wholesome. Food is stored in an area that is clean, dry and free from contamination. Food is stored, prepared and transported at appropriate temperatures and by methods designed to prevent contamination or cross contamination.” *…“All stock is rotated with each new shipment, [old] stock is always used first.”

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection prevention and control measures were effectively implemented and followed for:*One of one sampled resident (26) with an indwelling catheter and who was dependent on staff for transfer assistance, toileting needs, and catheter care received those cares with necessary enhanced barrier precautions (EBP).*Three of three sampled residents (1, 9, and 28) who received medications per nebulizer equipment had their equipment maintained and stored properly when not being used.*One of two clean linen distributing carts lacked a suitable protective cover while transporting items.Findings include: 1. Observation and interview on 7/15/25 at 3:40 p.m. with resident 26 revealed she: *Was lying in her bed with a catheter bag hanging from the bed frame. *Had the catheter for a few months. *Stated that the staff had sometimes worn gowns and gloves when they cared for her. *A sign was hanging on the inside of her door from the Centers for Disease Control and Prevention (CDC) indicating the resident was on EBP (glove and gown use when providing contact care) and everyone must: “clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linens, Providing Hygiene, Changing briefs or assisting with toileting, Device care or use: central line, urinary catheter, feeding tube, tracheostomy, Wound Care: any skin opening requiring a dressing”. It also indicated, “Do not to wear the same gown and gloves for the care of more than one person.” Review of resident 26’s electronic medical record (EMR) and comprehensive care plan revealed: *She was admitted on [DATE]. *She had a diagnosis of neuromuscular dysfunction of the bladder (a condition where the bladder’s ability to store and release urine is impaired). *Her Brief Interview for Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact. *She was on EBP due to having an indwelling urinary catheter, and the staff had been required to wear a gown and gloves when assisting her with high-contact resident care activities. *She required two staff members to transfer using a mechanical lift. *Staff should have worn gloves and gowns when assisting her with transferring and her catheter care. Interview on 7/16/25 at 3:10 p.m. with CNAs BB and AA regarding resident 26 revealed: *She was dependent upon staff to assist her with transfers, toileting needs, and catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She had required the use of a mechanical lift (a mechanical lift and sling used to lift a person’s full body) for all transfers. *She was on EBP, so the staff should have worn gloves and gowns when assisting her with toileting and her catheter care. *They stated they did not need to wear gloves and gowns for her transfers, unless they helped her to the commode. *The gowns had been kept in the resident's closet in a tote. *They had used washable gowns, and they could have reused them if they left the room and were coming right back. Otherwise, they disposed of the gowns in a garbage bag and sent them to the laundry. Observation on 7/17/25 at 10:15 a.m. of CNAs J and I with resident 26 in her room revealed: *The surveyor entered the resident's room with her approval. *The resident had just showered, was in the shower chair with a shirt on, no clothes on her bottom half, and her catheter bag was lying on the floor. *Staff were standing next to her with a mechanical lift and had been hooking up the sling when the surveyor came into the room. *CNAs J and I were not wearing gowns or gloves. *Once the surveyor came into the room, CNA I walked over to the resident's closet to get gowns and gloves. There was only 1 gown left, and CNA I put on the gown and a pair of gloves. -CNA J did not wear any personal protective equipment (PPE, such as gowns and gloves) to transfer the resident to her bed. *After the resident was in bed, CNA J left the room while CNA I assisted the resident with dressing her bottom half. *CNA J: -Came back into the room with gowns and restocked the resident's tote. -Had not put on any PPE after she restocked the tote and before assisting CNA I with transferring the resident back into her wheelchair. *Once in her wheelchair, CNA I put the catheter bag on the floor without a barrier between it and the floor. Once they finished getting the resident situated, CNA I placed her catheter bag into a dignity bag and hung the catheter bag on the wheelchair. *Both CNA I and J performed hand hygiene when they left the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 7/17/25 at 2:34 p.m. with infection preventionist C regarding the above observations revealed she: *Expected the CNAs to follow the provider's policy to wear PPE during care and transfers of a resident on EBP. *Expected the CNAs not to reuse gowns after being worn, even if they were coming right back. *Expected the CNAs not to place the catheter bag on the floor, and stated it was concerning that they did that. *Stated that all CNAs were educated on PPE use at their recent extravaganza educational event. *Provided the surveyor with copies of the staff education, CDC signs, and a pocket guide for CNAs from the CDC about EBPs. Interview on 7/17/25 at 3:50 p.m. with director of nursing (DON) B revealed she would have expected the staff to follow their EBP policy. Review of the providers' revised February 2024 Enhanced Barrier Precautions policy revealed: *“EBPs are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. -1. EBPs are used as an infection prevention and control intervention to reduce the spread of MDROs to residents. -2. EBPs employ targeted gown and glove use during high contact resident care activities when contract precautions do not otherwise apply. --a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room). --b. PPE is changed before caring for another resident. --c. Face protection may be used if there is also a risk of splash or spray. -3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include but are not limited too: --a. dressing --b. bathing/showering --c. transferring --d. providing hygiene (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--e. changing linens --f. changing briefs or assisting with toileting --g. device care or use (… urinary catheter…) --h. wound care -4. EBPs are indicated…. -5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. -6. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk. -7. The use of EBPs does not impose…. -8. Standard precautions apply to all care of all residents regardless of suspected or confirmed infection or colonization status. -9. Staff are trained prior to caring for residents on EBPs. -10. Signs are posted in the door or wall outside the resident's room indicating the type of precautions and PPE required. -11. PPE is available inside the resident rooms. -12. Residents, families and visitors….” 2. Observation and interview on 7/15/25 at 9:27 a.m. with resident 1 in her room revealed: *She had a nebulizer machine (a device that converts liquid medication into an inhalable mist) on her bedside table next to her recliner chair. *The nebulizer tubing and mask were attached to the nebulizer machine, and liquid was visible in the medication reservoir. *The nebulizer mask was lying directly on the bedside table without a barrier. Review of resident 1’s electronic medical record (EMR) revealed: *The nebulizer mask and parts were to be rinsed after each use and washed after the last treatment of the day. *The nebulizer mask and tubing were to be replaced every Saturday. *Nursing staff were to complete and document lung assessments before and after each treatment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview on 7/15/25 at 9:43 a.m. with resident 28 in her room revealed: *She had a nebulizer machine on her nightstand. *The tubing and nebulizer mask were attached to the machine. Liquid was visible in the medication reservoir. *The nebulizer mask was resting uncovered, directly on the nightstand without a barrier. Observation and interview on 7/15/25 at 2:30 p.m. with resident 9 in her room revealed: *She had a nebulizer machine on her nightstand. *The mask and tubing were attached to the nebulizer machine, and there was liquid visible in the medication reservoir. *The nebulizer mask was lying uncovered on the nightstand, with no barrier between the mask and the nightstand. Observation on 7/17/25 at 8:13 a.m. in resident 9’s room revealed that the nebulizer mask and tubing remained attached to the machine and were again lying uncovered on the nightstand without any barrier. Interview on 7/17/25 at 8:40 a.m. with infection preventionist (IP) C revealed that she would expect nebulizers to be rinsed after each use and cleaned daily, as per facility policy. Interview on 7/17/25 at 11:23 a.m. with DON B revealed: *Nebulizer masks and tubing were to be replaced once a week. *Nebulizer masks were not to be left without being placed on a barrier. *Nebulizer masks should have been rinsed and stored properly after the treatment and in accordance with their policy. Review of the provider's May 2025 Policy and Procedure: Administering Medications Through a Nebulizer revealed: *Procedure -When the nebulizer is complete, remove the mask or take the nebulizer unit from the resident. -Wash the nebulizer equipment per nebulizer care and cleaning procedure. Review of the provider's May 2025 Policy and Procedure Cleaning a Nebulizer revealed: *Purpose (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-To prevent the growth of bacteria on nebulizer equipment.” *“Procedure after each use: -Remove the tubing from the mask or mouthpiece and aerosolize cup. -Rinse with warm tap water between each medication. -Allow to air dry on clean barrier in bowl. *Procedure at end of day: -Remove the tubing from the mask or mouthpiece and aerosolize cup. -Disassemble the pieces and wash them in warm soapy water. -Rinse under a steady stream of warm water. -Allow to air dry on a clean barrier in the bowl, place in the bottom drawer of bathroom or in resident closet. -Mask and/or mouthpiece and tubing will be changed weekly. -Filter will be changed monthly by Care Team Tech (CTT) or designee. 3. Observation and interview on 7/17/25 at 10:21 a.m. with laundry assistant T revealed: *She had worked in the laundry department for about a year and a half. *The linen cart used to deliver clean linen to residents did not have a cover that enclosed the rack. It was open on the ends. *The cover was made of fabric, which was not cleanable. *She stated the cover was supposed to be temporary and that a new cover was supposed to have been ordered for the linen cart. Interview on 7/17/25 at 11:34 a.m. with IP C revealed: *She confirmed the linen cart was not enclosed by the current cover. *She stated she thought the fabric was machine-washable but was unsure if that was being done and that she would follow up with environmental services director/housekeeping S to confirm. Interview on 7/17/25 at 11:47 a.m. with IP C and environmental services director/housekeeping S revealed: *They agreed the linen cart cover “is not ideal.” (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435076	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	1001 S Egan Ave Madison, SD 57042

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*They confirmed that it was not being machine washed. *They confirmed it did not enclose the linen cart, and did not cover the linen to prevent cross-contamination. Review of the provider’s 2001 “Laundry and Bedding, Soiled” policy revealed: *Transport -“Linen carts are cleaned and disinfected whenever visibly soiled and according to the established schedule.” -“Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. ” *Storage -“Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated spaces with a closing door are used to reduce the risk of accidental contamination.”