STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435080	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethesda of Beresford	606 W Cedar Beresford, SD 57004

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, record review, observation, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (40) who eloped (left the facility without staff knowledge).Findings include:1. Review of the provider's 7/9/25 submitted SD DOH FRI regarding resident 40 revealed:*On 7/9/25 at 1:44 p.m. resident 40 was found on the east side of the building by certified nursing assistant (CNA) M.*CNA M brought her back into the facility and notified the registered nurse (RN) N.*Staff determined she had exited the facility through the east door in the therapy department.*The door leading into the therapy department had been propped open and the east door leading to outside was unalarmed.*She did not recall leaving the facility and her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits.*Therapy staff were educated that they needed to keep the door to the therapy department shut.*A sign had been placed on the door indicating to staff to keep it shut at all times. Review of resident 40's electronic medical record (EMR) revealed:*She was admitted to the facility on [DATE].*She had a diagnosis of paranoid schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly) and generalized anxiety disorder.*Her Brief Interview of Mental Status (BIMS) assessment score was 4, which indicated she had severe cognitive impairment.*Her 6/23/25 elopement evaluation indicated she was not at risk for elopement.*She needed supervision while walking and wandered the facility without a purpose.*She did not use assistive devices for walking.*She occasionally pushed on the exit doors until they alarmed and would forget that she needed help when exiting the facility.*Her progress notes revealed she wandered consistently in the hallways and would push on exit doors, which, if alarmed, would sound an alarm to alert staff that the door had been opened.-On 6/23/25 at 2:06 p.m. the therapy department notified the nursing staff she had gotten into the therapy room and had tried to use the exit door. -On 7/1/25 and 7/5/25 she had set off the door alarms.-On 7/9/25 at 12:56 p.m. she had attempted to exit the 100-hall door.-On 7/9/25 at 2:10 p.m. she had eloped and was found walking in the parking lot towards the road.-On 7/10/25 she attempted to exit the 100-hall door.-On 7/12/25 she attempted to exit the front door with another resident.-On 7/13/25 she had been at the 100-hall door and stated to staff that you could push on the door for 10 seconds and it would open because the sign on the door said so.-On 7/16/25 and 7/18/25 she had set off the door alarms.*On 7/25/25 she was sent to the hospital for a mental health evaluation and placed on a mental health hold.-The resident had been discharged and was no longer at the facility. Observation on 8/11/25 at 3:35 p.m. revealed the door to the therapy room had a sign on it stating to keep it shut at all times. Observation on 8/12/25 at 1:55 p.m. revealed the door to the therapy room had been propped open. Observation on 8/13/25 at 1:12 p.m. revealed that the door to the therapy room had been propped open. Interview on 8/13/25 at 10:44 a.m. with CNA H regarding resident 40 revealed she wandered the hallways constantly and would set off the door alarms. Interview on 8/13/25 at 10:53 a.m. with RN I regarding resident 40 revealed:*She did not seem to try to exit the facility in the beginning of her stay.*She had eloped through the therapy department door.*The therapy department had been educated to keep their door shut.*There was a key hanging on the wall beside the door to get into the therapy room.*Resident 40 was no longer at the facility because she needed a mental health evaluation. Interview on 8/13/25 at 1:53 p. m. with interim director of nursing (IDON) B and administrator A revealed:*The door to the therapy department had been propped open the past two days due to a contracted worker installing an alarm to the therapy department's east door exit.*The administrator had told that worker that he needed to keep the door closed.*The administrator confirmed that she had educated the therapy department about keeping the door closed.*They stated they thought that the elopement occurred because it was a system failure, which was corrected by installing an alarm on the door inside the therapy department.*The administrator confirmed that all other doors in the facility were alarmed.*IDON B did not think that resident 40 had exit seeking behaviors because she had never tried to pack her bags or state to staff that she wanted to leave the facility.*IDON B believed that to determine if residents were at risk for elopement, exit seeking behaviors needed to be intentional.*IDON B confirmed that resident 40 was not re-evaluated for risk of elopement after she eloped because she did not think it was necessary.*IDON B confirmed that interventions for elopement had not been documented in resident 40's care plan after she had eloped. Review of the provider's undated Elopement policy revealed:* To assess and identify residents at risk of elopement. To provide a system of

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. (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 0695 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, record review, policy review, and manufacturer's guideline review, the provider failed to ensure:*Oxygen equipment for two of two sampled residents (3 and 28) who required the use of supplemental oxygen was kept off the floor and appropriately serviced.*Infection control practices had been followed by three of three staff members (registered nurse (RN) J, certified nursing assistant (CNA) K, and CNA L) to minimize the risk of contamination to the oxygen tubing, for one of one sampled resident's (3) who required the use of continuous oxygen.*One of one sampled resident (3) received oxygen as ordered by the physician.*One of one sampled resident's (28) continuous use of oxygen at night was addressed in the resident's care plan. Findings include:1. Observation and interview on 8/12/25 at 9:05 a.m. with resident 3 while he was in his bed in his room revealed:*He communicated with sounds and gestures.*He had an oxygen (O2) concentrator (a device that filters room air into purified oxygen) next to his dresser, near the bathroom, which contained:-An undated O2 tubing and nasal cannula tubing (flexible tubing with prongs that delivers oxygen through the nose).-A humidifier bottle that did not contain any liquid.-An orange medical supply service sticker indicated that the O2 concentrator had been serviced on 7/30/24 and was due for service on 7/25.*The filter on the back side of the concentrator was missing.*An open jug of purified water dated 6-9 was on the table next to the O2 concentrator, which contained approximately one inch of water. *His wheelchair, located in the bathroom, had a portable O2 tank on it with an undated O2 nasal cannula tubing attached to it hanging towards the floor. Review of resident 3's electronic medical record (EMR) revealed:*He was admitted on [DATE].*His diagnoses included emphysema (a chronic lung disease), chronic obstructive pulmonary disease (a lung disease that blocks airflow and makes it hard to breathe) (COPD), obstructive sleep apnea (a chronic condition in which the throat muscles relax during sleep and the airway may become partially or fully blocked), and dementia (a group of symptoms affecting memory, thinking, and social abilities).*His 7/31/25 Minimum Data Set assessment indicated his speech was unclear, with slurred or mumbled words, and he sometimes made himself understood with limited ability to make concrete requests. *A 2/24/23 physician order indicated Change oxygen and/or nebulizer [a device that converts liquid medication into an inhalable mist] equipment and clean filters one time a day every 2 [two] weeks on FRI [Friday] for infection control. *A 12/20/24 physician's order indicated ensure that oxygen is in place and oxygen in tank two times a day.*A 2/19/25 physician order indicated Oxygen continuously at 3L [liters] per nasal cannula.Keep oxygen levels above 90% [percent].*His current care plan included:- I have COPD and acute on chronic respiratory failure.- I have obstructive sleep apnea and I wear oxygen at night and throughout the day to maintain my oxygen SATs [saturation level].- I have an oxygen tank in my wheelchair. I sometimes do not want to wear the oxygen and will take it off at my discretion. I often will become distressed by this decision. Please encourage me to always keep it on. Observation and interview on 8/13/25, starting at 9:30 a.m. in resident 3's room revealed:*Resident 3 was in bed and was not wearing his oxygen. His undated O2 nasal cannula tubing was on the floor in front of his O2 concentrator.*At 9:34 a.m. CNA K and CNA L entered resident 3's room.-CNA L shut off resident 3's O2 concentrator, picked the nasal cannula up off the floor, coiled up the nasal cannula tubing, and placed it in a blue bag that hung from his dresser drawer. --CNA K explained that the blue bag was where resident 3's oxygen nasal cannula was to be stored when he was not wearing it between uses.*CNA K stated that the red spots on resident 3's pillow and t-shirt were blood from his bloody nose. She thought that his nose was dry from his oxygen use.*CNA L and CNA K assisted resident 3 with personal hygiene, using the toilet, and getting dressed, and then assisted him into his wheelchair.-Resident 3 had not worn his oxygen during any of those activities.*Resident 3's nose bled off and on. He wiped his nose several times with his hand, and CNA K used a tissue and blotted blood from his left nostril.*Once seated in his wheelchair, resident 3 communicated with CNA L and CNA K with grunting sounds and gestures. He pointed to his O2 concentrator and touched his face several times. He took deep breaths, leaned forward, and appeared frustrated.*CNA K stated that she needed a new oxygen tank for resident 3's wheelchair and that she would put his oxygen on as soon as she changed that tank. She then left his room while pushing him in his wheelchair. Observation and interview on 8/13/25 at 10:01 a.m. with CNA K and resident 3 in the oxygen storage room revealed:*At 10:02 a.m. CNA K placed the nasal cannula that had been attached to the portable oxygen tank on resident 3 and turned it on. She stated he received three liters of oxygen.-Resident 3 had been without oxygen for at least 30 minutes.*CNA K confirmed that

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and policy review, the provider failed to follow standard food safety practices to ensure:*Documentation was completed consistently for two of two weekly scheduled cleaning tasks of the kitchen.*Temperature monitoring and documentation was completed consistently for one of one coffee machine.*One of one dietary aide (O) had washed her hands before and after serving and touching resident food items to prevent potential contamination.Findings include:1. Observation on 8/11/25 at 1:50 p.m. in the kitchen revealed:*A binder containing the weekly kitchen cleaning schedules.*The binder indicated staff needed to initial a task when it was completed. *On the 8/4 - 8/10 weekly cleaning schedule 13 out of the 40 listed tasks were not marked complete.*On the 7/28-8/3 weekly cleaning schedule 14 out of the 40 listed tasks were not marked complete. 2. Observation on 8/11/25 at 2:45 p.m. in the dining room revealed:*A coffee machine on the counter by the kitchen doorway.*There was a temperature log taped to the side of the coffee machine dated August 25.*There were three columns labeled for breakfast, lunch, and supper to document the temperature of the coffee.-Out of the 33 areas to document coffee temperatures on that log, only 6 had documented temperatures.*There was an education sign-in sheet for hot liquid temperatures taped next to the temperature log on the coffee machine.-It indicated staff understood how to properly check and document the temperatures of hot liquids.-It had 11 staff signatures on it. Interview on 8/13/25 at 5:00 p. m. with dietary aides F and E in the dining room regarding the coffee machine temperature sheet revealed:*Dietary aide F stated the kitchen staff no longer needed to check the temperature of the coffee machine because it had been calibrated to be at the correct temperature.*Dietary aide E stated that kitchen staff still needed to check the temperature of the coffee even though it had been calibrated. 3. Observation on 8/11/25 at 4:30 p.m. of dietary aide O in the kitchen revealed:*No hand hygiene was observed:-Before or after she checked the temperatures of food items for the supper meal.-Before or after she served the residents' plated meals during the supper meal service.-Before or after she grabbed a resident's sandwich from a plastic bag from the refrigerator and placed it on a plate with her bare hands. Interview directly after the supper meal service with dietary aide O revealed she should have performed hand hygiene before and after checking the food temperatures, before and after serving the supper meal service, and before and after touching resident food items. 4. Interview on 8/13/25 at 10:36 a.m. with dietary manager C revealed:*He expected the kitchen staff to perform hand hygiene before serving meals to residents and before and after they touched resident food items.*He expected the kitchen cleaning tasks to be completed as scheduled and the logs to be filled out to indicate those tasks had been completed daily.*The coffee machine had been calibrated to ensure it would be the correct temperature for resident safety, but he still expected staff to check the temperature with a thermometer and document those temperatures on the coffee temperature log. 5.Interview on 8/13/25 at 5:29 p.m. with administrator A revealed:*She expected staff to be checking the temperature of the coffee machine daily even if the machine had been calibrated.*The provider did not have a policy regarding how to check the temperature of food items.*She expected staff to clean the kitchen and perform hand hygiene appropriately. Review of the provider's 4/24/24 Sanitation of Dietary Department policy revealed:* The dietary staff shall maintain the sanitation of the Dietary Department through compliance with a written, comprehensive cleaning schedule.* A cleaning schedule shall be posted weekly for all cleaning tasks, and employees will initial tasks as completed. Review of the provider's revised 5/22/25 Hand Hygiene policy revealed:* It is the policy of Bethesda of [NAME] that all staff practice accepted hand hygiene in order to help prevent the spread of infection.* Hand hygiene should be performed, but not limited to:-Before and after feeding residents, perform in between when feeding residents if you touch a resident, touch food, or touch utensils touched by a resident (if assisting more than one resident).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 infection control practices were followed by failing to place one of one sampled resident (23) with an open surgical wound on his ear on enhanced barrier precautions (EBP) (gloves and gown use when providing contact care).Findings include: 1. Observation on 8/11/25 at 3:38 p.m. of resident 23 in the hallway revealed there was a bandage on his right ear that appeared to be soaked with blood. Record review of resident 23's electronic medical record (EMR) revealed:*He was admitted to the facility on [DATE].*He had a diagnoses of squamous cell carcinoma (a type of skin cancer originating from the outer layer of the skin) of the skin of the right ear and the external auricular (ear) canal. *He had seen a dermatologist to remove the area of skin cancer on his right ear.*His power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) was informed that the surgical wound on his right ear would be slow healing.*A skin evaluation on 8/11/25 of his surgical wound indicated there was small amount of drainage and the wound bed appeared red with lump-like tissue.*There was no mention of the resident being placed on enhanced barrier precautions in his EMR documentation. Observation on 8/12/25 at 10:43 a.m. of resident 23's room revealed:*There was no sign posted inside or outside of his room that indicated he was on enhanced barrier precautions.*There was no personal protective equipment (gowns and gloves) (PPE) available inside or outside of his room for staff to use while providing his contact care needs. Observation and interview on 8/13/25 at 9:34 a.m. with registered nurse (RN) I in resident 23's room revealed:*Resident 23 had an open wound on his right ear due to a surgical procedure.*She performed hand hygiene and put on a pair of gloves. *She removed resident 23's dressing for the surveyor to observe the open wound.*She reapplied the dressing, removed her gloves, and performed hand hygiene.*She confirmed that the resident had not been on EBP since his surgical procedure on 6/19/25. Interview on 8/13/25 at 1:53 p.m. with interim director of nursing/infection preventionist B revealed resident 23 should have been on EBP due to his open surgical wound on his right ear. Review of the provider's 4/1/2024 Enhanced Barrier Precautions policy revealed:* Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi-drug-resistant organism] as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices.)* High-contact resident activities include: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care, wound care: any skin opening requiring a dressing.* Wound in relation to this guidance, this generally includes residents with chronic wounds.* Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers.