STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Sioux Falls	1901 South Holly Avenue Sioux Falls, SD 57105

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), record review, interview, and policy review the provider failed to ensure 25 of 25 sampled residents on Promise Lane (1,2,3, 5,6,7,8, 9, 10, 11,12, 13, 14, 20, 21, 22, 23, 25, 26, 27, 28, 36, 38, 39, and 40) had their blood sugar checked and received treatment and medications as ordered by one of one registered nurse (RN) F during a twelve-hour shift. Findings include: 1. Review of SD DOH FRI submitted on 10/9/24 revealed: *On 10/6/24 RN F had left her unit from 9:00 a.m. until 11:00 a.m. and staff were unable to locate her during this time. *Certified nursing assistant (CNA)/medication aide N had to remind RN F multiple times to give morning narcotics for three residents, but she never saw RN F go in or out of those rooms to give those medications, but they were signed off. 2. Review of the provider's investigation documentation indicated the 10/6/24 video camera footage was reviewed and revealed RN F: *RN [NAME] the unit at 6:27 a.m. Her shift began at 6:00 a.m. Then she: -Counted the narcotics with off-going nurse at 6:42 a.m. -Left the unit at 8:17 a.m. and returned at 9:47 a.m. -Entered the narcotic medication drawer and retrieved all the narcotic blister packs from that drawer, and did something with them on the treatment cart, retrieved the narcotic sign out binder and was signing it. -Administered a medication at 4:56 p.m. to resident 36. --Only had been visualized via video camera administering medication to one resident throughout her shift. -Retrieved a medication at 4:58 p.m. from the top drawer of the medication and took it. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gave report at 6:11 p.m. to on-coming nurse. -Counted the narcotics at 6:20 p.m. with the on-coming nurse. -The count was correct. 3. Review of the provider's 10/11/24 resident chart audit for the resident's RN F had been responsible for during her 10/6/24 shift revealed: *Resident 1 should have had a lidocaine 4% patch (for pain) applied to both of her shoulders. *Resident 2 should have had an Aspercreme 4% patch (for pain) applied to her lower back and Voltaren gel (for pain) to her hands at 8:00 a.m. and 12:00 p.m. *Resident 3 should have had the dressing changed to her right leg incision and Oxycodone 2.5 milligrams (mg) (for pain) given at 8:00 a.m. and 12:00 p.m. *Resident 5 should have had her blood sugar checked at 7:00 a.m. RN F had documented the resident's blood sugar result 103 mg/deciliter (dL). *Resident 6 should have had applied Triad paste (for wound healing) applied to her bottom, received Tresiba insulin 35 units subcutaneously, and had her blood sugar checked three times and had insulin administered to her based on her sliding scale subcutaneously as needed. RN F had documented the resident's blood sugar results as: -At 8:00 a.m. 201 mg/dL and had administered six units of sliding scale insulin. -At 11:00 a.m. 201 mg/dL and had administered six units of sliding scale insulin. -At 5:00 p.m. 203 mg/dL and had administered six units of sliding scale insulin. --At 9:00 p.m. 600 mg/dL. Avel e-health had been notified and orders received for extra insulin. *Resident 7 should have had been given a Brovana 15 micrograms (mcg) nebulizer (for breathing problems) at 8:00 a.m. and a budesonide 0.5 mg nebulizer (for breathing problems) at 8:30 a.m. and 3:30 p.m. *Resident 8 should have had a Lidocaine 4% patch (for pain) applied to his back in the morning. *Resident 9 should have had Vaseline applied to her lips. *Resident 10 should have been given a Duoneb unit dose nebulizer (for breathing problems) at 7:00 a.m., 11:00 a.m., and 5:00 p.m., Humulin 14 units subcutaneously at 8:00 a.m. and six units subcutaneously at 6:00 p.m. -RN F had documented the resident's blood sugar results as: --At 7:00 a.m. 103 mg/dL. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	--At 11:00 a.m. 103 mg/dL. --At 5:00 p.m. 103 mg/dL. *Resident 11 should have been given a Biscodyl suppository (for constipation). *Resident 12 should have had Triad paste (for wound healing) applied to her bottom. *Resident 13 should have been Lantus insulin 48 units subcutaneously at 7:00 a.m. and 5:00 p.m., blood sugar checks three times, Aspercreme 4% (for pain) ointment to her hands, and Lidocaine 4% patch (for pain) to both the resident's knees. RN F documented the resident's blood sugar result and sliding scale Novolog insulin administered as: -At 7:00 a.m. 243 mg/dL and administered four units of insulin subcutaneously. -At 11:00 a.m. 243 mg/dL and administered four units of insulin subcutaneously. -At 5:00 p.m. 133 mg/dL with no sliding scale insulin administered. *Resident 14 should have had a Lidocaine 4% patch (for pain) applied to her lower back and Oxycodone 2.5 mg orally at 8:00 a.m. *Resident 20 should have had his scalp cleansed and had a dressing applied. *Resident 21 should have had barrier cream applied to her coccyx. *Resident 22 should have had Calmoseptine cream (a skin protectant) applied to her buttock. *Resident 23 should have had her blood checked at 7:00 a.m. -RN F had documented a blood sugar result of 199 mg/dL. *Resident 25 should have had a dressing changed to his feet, Mupirocin cream (antibiotic) applied to his first and second toes, Ketoconazole 2% (antifungal) cream applied to his face, and Ketoconazole 2% shampoo to his scalp. *Resident 26 should have had Triad paste (for wound healing) applied to her buttock, a Duoneb unit dose nebulizer (for breathing problems), and a Pulmicort 0.5 mg nebulizer (for breathing problems) at 10:00 a.m. and 6:00 p.m. *Resident 27 should have had Lantus insulin 42 units subcutaneously, her blood sugar checked at 7:00 a.m. and 5:00 p.m. RN F had documented the following blood sugar results as: -At 7:00 a.m. 199 mg/dL. -At 5:00 p.m. 103 mg/dL. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Resident 28 should have had Levemir 25 units of insulin subcutaneously, zinc oxide ointment to her buttock, and a blood sugar check. RN F had documented a blood sugar result of 102 mg/dL. *Resident 36 should have her blood sugar checked three times with sliding scale Humalog insulin administered as needed with blood sugar checks. RN F had documented resident's blood sugars results as: -At 7:00 a.m. 101 mg/dL with no sliding scale insulin administered. -At 11:00 a.m. 101 mg/dL with no sliding scale insulin administered. -At 5:00 p.m. 133 mg/dL with no sliding scale insulin administered. *Resident 38 should have had Biofreeze (for pain) applied to both of his knees, Lidocaine 4% gel (for pain) applied to the lower back, and Oxycodone 5 mg orally at 8:00 a.m. and 12:00 p.m. *Resident 39 should have had Benadryl cream (for pain and itching) applied to both arms and legs. *Resident 40 should have had a blood sugar checked. RN F had documented a result of 103 mg/dL. 4. Interview on 11/7/24 at 2:40 p.m. with director of nursing (DON) B regarding the investigation regarding RN F's care of residents on 10/6/24 revealed: *DON B had reviewed the video footage for 10/6/24 involving RN F. *DON B had been able to verify RN F had not entered the above listed residents' rooms during her shift to provide the documented cares and medications. *She had interviewed other staff that had provided care for residents on the unit RN F had been assigned to on 10/6/24. -Those interviews had verified RN F had not been seen entering the above resident's rooms. *Education would be provided to all CNA's on 11/14/24 regarding the investigation results from this incident. *Education would be provided to all nurses on 11/21/24 regarding the investigation results from this incident. Review of the provider's November 2023 Prevention of Resident Abuse, Neglect, and Misappropriation of Resident Policy revealed: *Each resident living at [NAME] has the right to be free from abuse, neglect, and misappropriation of their property. [NAME] will enforce policies and procedures that protect each resident from abuse, neglect, and misappropriation of property by [NAME] employees, other residents, consultants, volunteers, employees of other agencies serving the resident, family members and legal guardians, friends or other individuals. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*[NAME] will not tolerate the abuse, neglect, or misappropriation of property of any resident by any employee, a consultant, or others working under the direction of [NAME]. The video surveillance for 10/6/24 was not made available for survey review during the survey.