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	12/18/2025

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 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), interview, record review, and policy review, the provider failed to ensure the safety for one of one discharged sampled resident (57) who eloped (left the facility without staff knowledge) from the front door of the facility on 8/29/25 and was reported to the facility by a community member. The facility's front door was not alarmed or monitored at that time of the resident's elopement. Findings include:1. Review of the provider's 9/2/25 SD DOH FRI involving resident 57 revealed:*On 8/29/25 at approximately 5:10 p.m., a community member called the facility to tell staff that the resident was at their home, a block away from the facility.*The staff had last seen the resident at approximately 4:00 p.m.*According to the provider's investigation, the resident left the facility at approximately 4:06 p.m. and walked to the community member's home. She had knocked on the community member's door, and they sat with her until a facility staff member arrived.*Resident 57's goal was to go to her cousin's home, which was in that neighborhood, but she was unsure exactly where that was. She walked independently with a front-wheeled walker.*She willingly returned to the facility with the staff member.*The resident and her family had a care conference earlier that day, and the resident's sons expressed concern about the resident returning to her home independently due to her impaired cognition (mental status).*The conference earlier that day had upset resident 57, and she had expressed that to the staff member when she was picked up from the community member's home.*The resident returned to the facility at approximately 5:20 p.m. and was assisted back to her room.*The resident's son, her primary care physician, the administrator, and the director of nursing (DON) were notified of the resident's elopement.*Resident 57's vital signs after she returned to the facility on 8/29/25 were: blood pressure 128/69, pulse 80, temperature 98.0, respirations 18, oxygen saturation 95%. Her skin assessment was completed and was normal.*She was placed on 15-minute checks by staff to ensure she was in the facility and safe. 2. Review of resident 57's closed electronic medical record revealed:*She was admitted to the facility on [DATE] to the rehabilitation (rehab) unit on [NAME] Boulevard Hall following a hospitalization for a syncope incident (fainting) with collapse.*Her discharge plan was to go to an assisted living facility after completion of skilled therapies.*Her BIMS (brief interview for Mental status) score was seven, which indicated her cognition was severely impaired.*One of her sons was her responsible party and assisted her with health decisions.*She worked with therapy services five times per week.*Her diagnoses were syncope and collapse, and Hypotension (low blood pressure).*She was discharged from the facility to her home on 9/3/25 AMA (against medical advice) with her son, who was responsible for her. 3. Interview on 12/17/25 at 2:30 p.m. with CNA (certified nurse assistant) C revealed:*He vaguely remembered an elopement incident on 8/29/25 for resident 57.*He did not think that resident 57 wandered and would exit seek. *He did rounds on residents to check on them every two hours or less.*Exit doors would be locked in the back of the building, and he did not remember responding to a door alarm that day (8/29/25).*He found out there was a resident elopement when the DON had called over the radio that she was going to pick up a resident outside of the facility. 4. Interview on 12/17/25 at 2:36 p.m. with DON B revealed:*Resident 57 had a wander assessment on admission 8/5/25 and scored a 5, which indicated moderate risk for elopement, due to mobility, and she had not verbalized a desire to leave.*She had reviewed the camera footage for 8/29/25 when the resident eloped. She indicated resident 57, who used a wheeled walker independently, had left the facility going out the front door around 4:15 p.m. that day.*The front door that the resident had exited out of should have been locked and alarmed automatically at 4:30 p.m. that day. Prior to that time the front door should have been monitored by staff when it was not alarmed, but the administrative assistant (AA) D located at the front desk had stepped away to make copies in the administrative hall, and that door was not monitored or locked at the time the resident exited the facility. The AA D had not alarmed the door or notified staff to monitor the door while she stepped away. *She stated the front door should have been monitored by staff on [NAME] Boulevard Hall by camera. She could not confirm the cameras would be monitored by staff if that staff person was distracted by talking with someone or not watching the camera at all times, and she agreed that was a concern.*She stated on 8/29/25, the day of resident 57's elopement incident, a care conference with the resident and her two sons was held earlier. She stated that one of the resident's sons (responsible party) was okay for her to return to her own home alone, and the other son was not okay because she lacked awareness of her dementia (a group of symptoms affecting memory, thinking, and social abilities) and he was concerned about her safety