

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>50915</p> <p>Based on record review and policy review, the provider failed to provide Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) for one of three (247) sampled residents. This citation is considered past non-compliance based on review of the corrective actions the provider implemented following the incident. Findings include:</p> <p>Review of provider's documentation regarding advanced beneficiary notices (ABN) revealed on 10/11/24, the provider identified previous social worker (SW) O had not been completing SNF ABNs or NOMNCs for residents who received Medicare Part A skilled services.</p> <p>*Administrator A interviewed (SW) O and SW P on 10/16/24.</p> <p>-SW O had reported he was not trained upon his hiring on how to complete the ABNs by SW P.</p> <p>-SW P had reported she had trained SW O upon his hiring on how to complete the ABNs.</p> <p>Record review on 11/6/24 of the provider's SNF Beneficiary Notification Review Form CMS-20052 revealed:</p> <p>*Three randomly selected residents were given to the provider for review of SNF ABN.</p> <p>*Resident 247's Medicare A skilled services ended on 9/23/24, Resident 247 was not given the SNF ABN form CMS-10055 or NOMNC form CMS-10123 by the provider prior to the end of his Medicare skilled services.</p> <p>*Explanation on form CMS-20052 for why the above notifications were not given to resident 247 indicated, in plan of correction.</p> <p>The provider implemented actions to ensure the deficient practice does not reoccur. Plan of correction included SW P provided education to nurse manager D, DON B, and administrator A on SNF ABN and NOMNC completion. Beginning 10/25/24, administrator A or designee will audit each resident discharged to ensure SNF ABNs and NONMCs were completed timely. Findings from these audits will be reported to QAPI Committee. It was confirmed on 11/5/24 after record review revealed the facility developed a plan of correction and education was provided to those involved in SNF ABN and NOMNC issuance.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on the above information, non-compliance at F582 occurred on 10/11/2024, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/2024, the non-compliance is considered past non-compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>46453</p> <p>Based on interview and record review, the provider failed to provide a written notice of transfer or discharge and to notify the ombudsman of that transfer or discharge, for two of two sampled residents reviewed (31 and 45). This citation is considered past non-compliance based on review of the corrective actions the provider implemented after discovering the lack of documentation.</p> <p>Findings include:</p> <p>1. Interview and record review on 11/5/24 at 11:51 a.m. with administrator A revealed:</p> <ul style="list-style-type: none"> *Administrator A provided the survey team with a copy of their investigation timeline and their plan of correction (POC) documentation. *They discovered a lack of documentation for a variety of required notices on 10/11/24. *The management team completed an investigation to determine the extent of the issue. *The previous social worker was responsible for providing required notices to residents or their representatives. That former employee was not providing the required written notices, including transfer or discharge notices. *The nurse managers were educated on the required written notices on 10/16/24. *Chart reviews were conducted, and corrections were completed. <p>2. Review of resident 31's electronic medical record (EMR) revealed:</p> <ul style="list-style-type: none"> *She was transferred to the local emergency department on 5/24/24, and again on 9/1/24. *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified for either date. <p>3. Review of resident 45's electronic medical record revealed:</p> <ul style="list-style-type: none"> *She transferred to the local emergency department on 8/12/24. *There was no documentation found about a notice of transfer or discharge, or that the ombudsman was notified. <p>4. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about the required notices revealed that she was not sure if the notices were completed correctly due to an issue with the previous social worker.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse managers about required notices, interviews revealed staff understood the education provided regarding those topics, and a review of recently transferred or discharged residents revealed notices were provided as required.</p> <p>Based on the above information, non-compliance at F623 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance is considered past non-compliance.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46453</p> <p>Based on interview and record review, the provider failed to provide a written bed-hold notice to the resident or their representative when transferred to the emergency department for one of two sampled residents reviewed (45). This citation is considered past non-compliance based on review of the corrective actions the provider implemented after discovering the lack of documentation.</p> <p>Findings include:</p> <p>1. Interview and record review on 11/5/24 at 11:51 a.m. with administrator A revealed:</p> <ul style="list-style-type: none"> *Administrator A provided the survey team with a copy of their investigation timeline and plan of correction (POC) documentation. *They discovered a lack of documentation for a variety of required notices on 10/11/24. *The management team completed an investigation to determine the extent of the issue. *The previous social worker was responsible for providing required notices to residents. That former employee was not providing the required written notices, including bed hold notices. *The nurse managers were educated on the required written notices on 10/16/24. *Chart reviews were conducted, and corrections were completed. <p>2. Review of resident 45's electronic medical record revealed:</p> <ul style="list-style-type: none"> *She admitted to the facility on [DATE]. *She transferred to the local emergency department on 8/12/24. *The social worker spoke with the resident's representative about the bed hold policy on 8/12/24. Written notice was not documented. *The resident's representative verbally declined to hold the bed and gathered resident 45's belongings from the facility on 8/12/24. <p>3. Interview on 11/7/24 at 8:40 a.m. with nurse manager D about bed hold notices revealed:</p> <ul style="list-style-type: none"> *The written bed hold notices were unlikely to have been done due to a situation with the former social worker. *The resident had not requested to return to the facility as she was admitted to hospice services. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/5/24 after record review revealed the facility had followed their quality assurance process, education was provided to the nurse managers about required notices, interviews revealed staff understood the education provided regarding those topics, and a review of recently discharged residents revealed notices were provided as required.</p> <p>Based on the above information, non-compliance at F625 was discovered on 10/11/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 11/5/24, the non-compliance is considered past non-compliance.</p> <p>51370</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>51471</p> <p>Based on record review, interview, and policy review, the provider failed to ensure the care plan for two of two sampled residents (11 and 25) had been updated to reflect their current condition. Findings include:</p> <p>1. Review of resident 11's electronic medical record (EMR) revealed:</p> <p>*On 8/6/24 she had received a diagnosis for dementia and other diseases classified elsewhere.</p> <p>*On 8/15/24 an order had been received to start Seroquel 100 milligram (mg) by mouth one time a day related to Major Depressive Disorder.</p> <p>2. Review of resident 11's care plan revealed:</p> <p>*On 8/20/24 the care plan had been updated and indicated the use of scheduled psychotropic medications related to pain management and depression. No focus area on resident's diagnosis of dementia was noted in the care plan.</p> <p>3. Review of resident 25's EMR revealed:</p> <p>*On 8/23/24 an order had been received to start Apixaban 2.5 mg (blood thinner) for Atrial fibrillation by mouth two times per day for blood clot prevention.</p> <p>4. Review of resident 25's care plan revealed:</p> <p>*On 10/29/24 the care plan had been updated but did not indicate that the resident was started on Apixaban 2.5 mg, for the prevention of blood clots.</p> <p>5. Interview on 11/7/24 at 2:15 p.m. with director of nursing B, nurse manager D, and administrator A revealed:</p> <p>*The manager of each unit is responsible for updating the residents' care plans.</p> <p>* Any staff member who processes an order, is also responsible for updating the care plan.</p> <p>* During the interview, administrator A, DON B, and nurse manager D agreed that residents 11 and 25's care plans had not been updated to reflect their care needs.</p> <p>Review of the provider's October 2024 Care Plan policy revealed:</p> <p>* Care Plans will be updated by staff on an ongoing basis. This includes care plans being reviewed and updated with appropriate significant changes as well as quarterly. Significant changes could include recent hospital stays, new admissions to hospice, new acute diagnosis, and other traits that reflect a decline in physical and emotional status.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>* The nurse manager will complete a daily process such as daily walking event rounds, daily review of all new orders, daily review of 24-hour sheets, daily review of progress notes and/or daily review at IDT huddle in order to keep the care plan current. The nurse manager will utilize the plan of care to create CNA's daily/weekly care flowsheets.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>46453</p> <p>51370</p> <p>Based on menu review, observation, and interview, the provider failed to ensure adequate portions were served according to the menu for one of one observed meal. This had the potential to affect all residents receiving the main menu in the facility.</p> <p>Findings include:</p> <p>1. Review of the provider's menu for lunch on 11/7/24 revealed the following main menu items:</p> <p>*Beef & broccoli, #8 dip x2, which was eight ounces (oz.) total.</p> <p>*Diced carrots, four oz. spoodle.</p> <p>-A spoodle is a slotted scoop to drain the liquid.</p> <p>2. Observation on 11/7/24 at 11:11 a.m. in the kitchen during lunch service revealed:</p> <p>*Cook L was plating the residents' lunch meal food items.</p> <p>*She served a three oz. scoop of the beef & broccoli.</p> <p>-The printed menu indicated the serving size for the regular diet as #8 dip x 2.</p> <p>*Cook L served a heaping two oz. spoodle of diced carrots.</p> <p>-The printed menu indicated the serving size as 4 oz.</p> <p>*Observation of the utensil drawer confirmed that a 4 oz. spoodle and a 4 oz. serving spoon were available.</p> <p>3. Interview on 11/7/24 at 1:29 p.m. with cook L revealed she:</p> <p>*Was aware of the serving sizes on the printed menu.</p> <p>*Chose not to use the correct serving sizes; she did not provide a reason.</p> <p>4. Interview on 11/7/24 at 1:34 p.m. with dietary manager G about the above observations revealed she:</p> <p>*Was not aware that dietary staff served the wrong portion sizes for lunch that day.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*Was aware of the need to meet the dietary requirements of the residents by following the approved menu, including portion sizes.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46453</p> <p>Based on observation, interview, and document review, the facility failed to maintain cleanliness in one of one steamer and one of one convection oven in the kitchen.</p> <p>Findings include:</p> <p>1. Observation during the initial kitchen tour on 11/5/24 from 11:43 a.m. to 12:19 p.m. revealed:</p> <ul style="list-style-type: none"> *The interior of the Vulcan brand convection oven was heavily coated in baked-on grease and food particles. *The interior of the Cleveland brand SteamChef steamer had an excessive buildup of limescale and scum, and there were food particles at the bottom of the basin sitting in standing water. <p>2. Interview on 11/7/24 at 10:45 a.m. with cook L about cleaning the large kitchen equipment revealed:</p> <ul style="list-style-type: none"> *She claimed that she cleaned the steamer and oven every day, and deep-cleaned them weekly. *That equipment had not been deep-cleaned in about a month. *She did not know the proper steps to clean the steamer. <p>3. Interview on 11/7/24 at 1:34 p.m. with dietary manager G about the oven and steamer revealed:</p> <ul style="list-style-type: none"> *There was a cleaning schedule for the kitchen equipment. *She performed monthly audits for kitchen cleanliness. *She was unaware that the oven and steamer were that dirty. *She did not know the proper steps to clean the steamer. <p>4. Review of the provider's monthly kitchen cleanliness audits revealed:</p> <ul style="list-style-type: none"> *The audits were completed on 8/26/24, 9/30/24, and 10/25/24. *There was a line item under the Maintenance section that read Ovens and Steamer clean and in good repair. -There was a checkmark Yes next to that line item on the above-listed audit sheets. <p>5. Review of the manufacturer's cleaning guidelines for the Cleveland SteamChef revealed they recommended descaling daily to prevent the buildup of minerals and limescale.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435096	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Bethany Home Sioux Falls		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>*When done daily this will help prevent the buildup of calcium and other mineral deposits left over from the boiling of water, and prevent scale buildup in the steamer, helping prevent more costly maintenance and service on the steamer.</p> <p>51370</p>		