STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435130	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home - Brandon	3012 E Aspen Blvd Brandon, SD 57005

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. (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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(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	Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, record review, and policy review, the provider failed to protect three of three sampled residents (16, 37, and 50) and one of one closed sampled resident (101) from alleged verbal abuse and neglect. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident.Findings include: 1. Review of the provider's 9/12/25 submitted to SD DOH FRI final report revealed:*On 9/11/25 at 9:28 a.m., director of nursing (DON) B received a text message from certified nurse aide/certified medication aide (CNA/CMA) Y about CNA/CMA N's interactions with residents in the Maple Valley neighborhood (residential living unit). That neighborhood was a memory care unit (an area where specialized care is provided in a structured, safe, and supportive environment to meet the unique needs of residents with significant memory and cognitive decline, which is secured to minimize unsafe wandering). In her text message, CNA/CMA Y indicated CNA/CMA N was:-Withholding fluids from residents during meals because the residents had made a mess [drinking their fluids] or they won't eat they'll be full of their drinks. -Denying resident 50's request for coffee. [Resident 50] had been asking for hours for coffee and [CNA/CMA N] kept yelling and saying NO.-Not allowing resident 35 to leave the dining room table during a meal after she [resident 35] had mentioned being full. She [CNA/CMA N] was making her [resident 35] more agitated by forcing big bites in her mouth and yelling 'EAT!'. In a similar instance, CNA/CMA Y had informed CNA/CMA N that resident 101 had finished eating when she [CNA/CMA N] tried to shove a huge bite [of food] in his mouth because 'he's [the resident] not eating enough' and he spit it [the food] at her.-Yelling at residents quite often and I [CNA/CMA Y] feel like it creates anxiety and they [the residents] have more behaviors. -Scolding resident 16, who loves to change her outfits, for wanting to change her clothes too often. CNA/CMA N stated, You're [CNA/CMA Y] creating work for us and laundry. 2. Interviews on 12/17/25 at 10:10 a.m. and 1:45 p.m. with DON B and review of CNA/CMA N's personnel record revealed:*CNA/CMA N's date of hire was 10/15/24. She had a complete and timely background check that was reviewed. Her CNA and CMA certifications were up to date. She had completed resident rights, dementia, and abuse/neglect education in October 2025. There were two disciplinary actions (11/15/24 and 12/24/24) in her file regarding medication administration errors. DON B stated she was not aware of any concerns related to CNA/CMA N's care or treatment of residents before the 9/11/25 text she received from CNA/CMA Y. *CNA/CMA N was suspended from work on 9/11/25 at 11:00 a.m. pending an investigation of CNA/CMA Y's allegations. CNA/CMA N self-terminated after that suspension and was not interviewed regarding the allegations due to her no longer working at the facility.*Additional staff interviews completed by DON B after 9/11/25 regarding CNA/CMA N's care and treatment of residents in the Maple Valley neighborhood supported the allegations made by CNA/CMA Y. DON B confirmed the FRI was substantiated for CNA/CMA N's behaviors towards the residents. *Staff education was initiated on 9/11/25 and included a review of the provider's Abuse/Neglect policy. Staff signed and dated an individual acknowledgement of their understanding of the education that was provided for them. Beneath their signature was the following statement: This form may be used for all types of counseling, including warning records and disciplinary action records.*Two audits were initiated related to the above event. An Abuse/Neglect audit focused on the respectful treatment of residents, resident privacy, the provision of care to meet residents' needs, and staff interactions with residents during care provision. A Staff Reporting audit focused on staff observations of other caregivers, including their interactions with and treatment of residents; if an observation was considered abusive or neglectful, was it appropriately reported, and finally, the audit included whether or not the staff understood the reporting requirements in the facility's Abuse/Neglect policy.3. Interview on 12/17/25 at 10:20 a.m. with CNA/CMA AA and telephone interview on 12/17/25 at 10:40 a.m. with CNA/CMA Z confirmed they were provided education in September 2025 regarding resident abuse and neglect and the expectations for reporting resident abuse and neglect. They described the audits that occurred after the education was provided, which reinforced the importance and understanding of that education.4. Observation on 12/16/25 at 9:30 a.m. of CNA/CMA AA with resident 7 in the Maple Valley neighborhood revealed CNA/CMA AA assisted the resident into her room to complete the resident's morning grooming and personal care. There were no concerns regarding CNA/CMA AA's care or treatment of the resident.5. Observation on 12/16/25 at 10:00 a.m. of CNA/CMAs AA and BB with resident 37 in the Maple Valley neighborhood revealed that the CNA/CMAs assisted the resident into his room. They used a mechanical lift