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	05/28/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure resident privacy and dignity during the administration of personal care treatments for two of two sampled residents (1 and 4) who were administered vaginal cream in the dining room by registered nurse (RN) L where other residents and staff were present. Findings include1. Review of the provider's 2/4/26 SD DOH FRI revealed that residents (1 and 4) had an order for medicated vaginal cream. Certified nursing aide/medication aide (CNA/MA) J reported that she witnessed RN L prepare and instill cream in the dining room for residents (1 and 4). 2. Review of resident 1's EMR revealed a physician's order for 1 gram (gm) Conjugated Estrogen Cream 0.625 mg/gm, to be inserted vaginally at bedtime every Monday, Wednesday, and Friday for urinary incontinence (unintentional passing of urine). Resident 1's 5/7/26 Brief Interview for Mental Status (BIMS) assessment score was 99, which indicated the assessment could not be completed. Her care plan indicated that the resident had impaired cognitive function/thought process related to dementia (a group of symptoms affecting memory, thinking, and social abilities). The staff was to communicate with the family about the residents' capabilities and needs. 3. Review of resident 4's EMR revealed that she was admitted to the facility on [DATE]. She had medical diagnoses that included dementia with other behavioral disturbances, Alzheimer's (a brain disorder that slowly destroys memory and thinking skills), urinary incontinence, chronic kidney disease (CKD) stage three (mild to moderate kidney damage), and anxiety (a feeling of worry, nervousness, or unease). Resident 4 had a physician's order for 1 gm of Estradiol Vaginal cream 0.1 milligram mg/gm to be inserted vaginally one time a day every Monday, Wednesday, and Friday for vaginal health. On 4/25/25, her Brief Interview for Mental Status (BIMS) assessment score was documented as not applicable (NA), which indicated her cognition was severely impaired. Her current care plan, dated 5/7/26, included that she had impaired cognitive function/thought processes related to her diagnosis of dementia, and to communicate with her family regarding her capabilities and needs. 4. Interview on 5/28/26 at 11:00 a.m. with registered nurse (RN) I revealed that oral medications and insulin are the medications she will give in the dining or public area. These are only administered if the residents give their permission. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Interview on 5/28/26 at 12:45 p.m. with CNA/MA J regarding the incident on 2/4/26 with resident 1 and 4 revealed she saw RN L prepare and then administer the vaginal cream to a resident sitting by the medication cart and a resident that was sitting at a dining table. She then notified DON B within thirty minutes, as she thought administering the vaginal cream in the dining room was not the right thing to do. 6. Interview on 5/28/26 at 2:32 p.m. with CNA/MA K revealed that oral medications are what she would administer in the dining area of the facility. She would ask the resident's permission prior to giving the medication. 7. Interview on 5/28/26 at 3:45 p.m. with DON B revealed she acknowledged that RN L administered vaginal cream to residents 1 and 4 in the dining room for those two residents. She agreed that was not an appropriate area to administer the cream and that medication of vaginal cream should be administered in privacy such as the resident's room. 8. Review of RN L's employee file revealed her employment with the facility was terminated on 2/6/26 due to the incident that occurred on 2/4/26. 9. Review of the provider's 11/18/22 Resident Rights Guidelines revealed [it is the resident's right to] maintain individual privacy and confidentiality. 10. Review of the provider's November 2022 Resident Dignity policy revealed Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. 1. Residents are treated with dignity and respect at all times. 2. The facility culture is on [one] that supports and encourages humanization and individuation of residents, and honors resident choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's stay in the facility. 10. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to report incidents to law enforcement and the ombudsman for two of two sampled residents (1 and 4) when they were administered vaginal medication in the dining room by one of one registered nurse (RN) (L). The facility failed to report to the resident's representative, primary care provider (PCP), law enforcement, and the ombudsman for one of one sampled resident (2) who was verbally abused by one of one certified nursing assistant (CNA) (M) when she provided resident 2 personal care. The facility also failed to report resident 2's incident within a timely manner to the SD DOH. 1. Review of the provider's 2/4/26 SD DOH FRI revealed that residents 1 and 4 had a physician's order for medicated vaginal cream. On 2/4/26 around 7:00 p.m. CNA/medication aide (MA) J reported that she witnessed RN L prepare and administer the vaginal cream to residents 1 and 4 in the dining room, where other staff and residents were present, by pulling their pants and incontinent (involuntary urine or bowel leakage) briefs down and to the side. The director of nursing (DON) B and Assistant director of nursing (ADON) D called and spoke with RN L. RN L stated to DON B and ADON D that she did administer the cream by pulling the resident's brief and pants out and putting her hand in the brief and squirting the cream in the vaginal area. The DON explained to RN L that this is improper administration of this medication and that the administration of this medication should be completed in the privacy of the resident's room. RN L was sent home from her shift and suspended at that time. The FRI revealed that the abuse/neglect allegation was substantiated as RN L acknowledged she did this incident. 2. Review of resident 1's electronic medical record (EMR) revealed an order for 1 gram (gm) of Conjugated (mixture of Estrogens) Cream 0.625 mg/gm, was to be inserted vaginally at bedtime every Monday, Wednesday, and Friday for urinary incontinence. Resident 1's 5/7/26 Brief Interview for Mental Status (BIMS) assessment score was 99, which indicated the assessment could not be completed by the staff. Her care plan indicated that the resident had impaired cognitive function/thought process related to dementia (a group of symptoms affecting memory, thinking, and social abilities). The staff was to communicate with the family about the residents' capabilities and needs. 3. Review of resident 4's EMR revealed that she was admitted to the facility on [DATE]. She had medical diagnoses that included dementia with other behavioral disturbances, Alzheimer's (a brain disorder that slowly destroys memory and thinking skills), urinary incontinence, chronic kidney disease (CKD) stage three (mild to moderate kidney damage), and anxiety (a feeling of worry, nervousness, or unease). She had a physician's order for Estradiol Vaginal cream 0.1 MG/GM insert 1 GM vaginally one time a day every Monday, Wednesday, and Friday for vaginal health. On 4/25/25, her Brief Interview for Mental Status (BIMS) assessment score was documented as not (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applicable (NA), which indicated her cognition was severely impaired. Her current care plan, dated 5/7/26, included that she has impaired cognitive function/thought processes related to her diagnosis of dementia, and to communicate with her family regarding her care and needs. She is incontinent at times and wears briefs for protection and dignity. 4. Interview on 5/28/26 at 12:45 p.m. with CNA/MA J regarding the incident on 2/4/26 with resident 1 and 4 revealed she saw RN L prepare and then administer the vaginal cream to a resident sitting by the medication cart and a resident that was sitting at a dining table. She then notified DON B within thirty minutes, as she thought administering the vaginal cream in the dining room was not the right thing to do. 5. Interview on 5/28/26 at 3:45 p.m. with DON B revealed she acknowledged that RN L administered vaginal cream in the dining room for those two residents. She agreed that it was not an appropriate area to administer the cream and that vaginal cream should be administered in privacy, such as the resident's room. 6. Review of RN L's employee file revealed her employment with the facility was terminated on 2/6/26 due to the incident that occurred on 2/4/26. 7. On 5/28/26 at 10:55 a.m., Department of Health surveyors requested documentation that the facility had notified law enforcement and the ombudsman of the incident on 2/4/26 regarding residents 1 and 4. Per DON B, no notifications were made to these entities because they did not classify it as an abuse concern, but rather as a dignity concern. 8. Review of the provider's 2/13/26 SD DOH FRI revealed that on 2/13/26 at 8:00 p.m., resident 2 was verbally abused by CNA M when she provided assistance with his personal care. CNA K reported this incident on 2/14/26 at 10:11 p.m.to DON B via text message. 9. Review of resident 2's EMR revealed his 4/23/26 Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. 10. On 5/28/26 at 1:12 p.m., Department of Health surveyors requested documentation that the facility had notified the ombudsman, family, and the resident's physician of this incident. Per Administrator A, no notification was made to these entities. 11. Review of CNA M's employee file revealed her employment with the facility was terminated on 2/19/26 due to the incident that occurred on 2/13/26. 12. Interview on 5/28/26 at 3:45 p.m. with DON B revealed that due to this incident, she has completed education with staff, including CNA K, on when and how to report concerns of abuse and neglect. She stated that depending on the staff title or position, they report to their supervisor. That information would then get to DON B, and she reports to administrator A. They both then start the investigation process, which she stated includes the notification of DOH, law enforcement, the Department of Human Services (DHS), family members, and the primary care provider. Staff involved in the incident are suspended during the investigation. She acknowledged that the facility has two hours to report allegations of abuse or a resident being injured, and 24 hours for anything else. 13. Review of the provider's June 2025 Abuse, Neglect, Exploitation or Misappropriation-Reporting and Investigating policy revealed The DON or their designees immediately reports his or her suspicion (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility; b. the local/state ombudsman (if applicable); c. the residents representative; d. Dakota at home; e. law enforcement officials; the resident's attending physician; and g. the facility medical director.

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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. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review, the provider failed to ensure the safety for one of one sampled resident (3) who fell onto the floor and hit his face while being pushed in his wheelchair by certified nursing assistant (CNA) (C), who did not attach and use the wheelchair foot pedals as required when transferring resident 3 to the dining room.Findings include: 1. Review of the provider's 3/3/26 SD DOH FRI revealed that on 3/3/26, resident 3 was being pushed in his wheelchair by CNA C to the dining room with no wheelchair foot pedals attached. Resident 3 put his feet down and fell forward onto the floor, hitting his face. Resident 3 was upset after the incident. He had a raised egg-shaped lump to the center of his forehead and open skin abrasions to the bridge of his nose. There was a small skin tear noted on his right hand between his thumb and pointer finger. The area was cleansed; skin was put back over, and a steri-strip bandage was applied. Neurological evaluations (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) (neuros) were started and found to be within normal limits for resident 3. His son, the director of nursing (DON) B, and administrator A were notified of the incident. Staff continued to monitor resident 3. CNA C acknowledged that she was not following the policy in ensuring residents are utilizing foot pedals when being pushed in a wheelchair. CNA was terminated immediately. 2. Review of resident 3's electronic medical record (EMR) revealed his 2/26/26 Brief Interview for Mental Status (BIMS) assessment score was 11, which indicated his cognition was moderately impaired. Resident 3's care plan dated 3/2/26 had an intervention added on 3/5/26 that indicated that foot pedals should be on resident 3's wheelchair at all times when someone was pushing him in his wheelchair. He had a history of putting his feet down while the wheelchair was moving and falling forward. 3. Interview on 5/28/26 at 11:00 a.m. with registered nurse (RN) I revealed she was the nurse who responded to the incident that occurred on 3/3/26, which involved resident 3 falling out of his wheelchair. Resident 3 was being pushed by CNA C to the dining room for breakfast, and had put his foot down onto the floor, which caused him to fall headfirst out of his wheelchair. Ecare (telehealth service that provides virtual medical services) was contacted by RN I and instructed her to monitor the resident. 4. RN I stated that the staff was trained to put the wheelchair pedals on, and CNA C did not. RN I indicated that assistant director of nursing (ADON) D and she had both told CNA C that the wheelchair pedals were to be put on when assisting a resident in their wheelchair. 5. Review of CNA C's personal file revealed she completed training on 2/4/26, which provided education that all residents must have wheelchair foot pedals on when the staff were pushing residents in their wheelchairs. 6. Interview on 5/28/26 at 3:45 p.m. with director of nursing (DON) B revealed that wheelchair foot pedals were to be attached to wheelchairs and used when the staff were assisting residents. 7. Review of the provider's reviewed April 2025 Use of Wheelchair Pedals policy revealed 1. Foot (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pedals will be used for residents who use wheelchairs while they are in their wheelchair, unless deemed safe and care planned otherwise.

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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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on a South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure residents were free of significant medication errors for one of one sampled resident (3) who received 2.5 milliliters (mL) of Morphine Sulfate (narcotic) by mouth instead of the ordered dose of 0.25 mL from a certified nursing assistant (CNA)/medication aide (MA) E and experienced decreased oxygen levels, lethargy (abnormal drowsiness or sluggishness that involves low energy, decreased alertness, reduced mental and physical activity), respiratory distress (trouble breathing), and required the use of Narcan (a medication that reverses the effects of opioids).Findings include:1. Review of the provider's 5/15/26 SD DOH FRI revealed that resident 3 had a physician's order for 0.25 mL of Morphine Sulfate, 100 milligrams (mg)/5 (mL), to be administered orally as needed for pain or shortness of breath (SOB).On 5/14/26 at 8:45 p.m., resident 3 was administered 2.5 mL of morphine from CNA/MA E, which was the incorrect dose. This was 2.25 mL of morphine over the prescribed dose. On 5/14/26 at 9:01 p.m., Ecare (telehealth service) was consulted and informed of the medication error of morphine that involved resident 3. They were directed to monitor the resident.Approximately twenty to thirty minutes after resident 3 received the incorrect dose, he experienced decreased oxygen levels, lethargy, respiratory distress, and required the use of Narcan. LPN F received an order for Narcan and administered the dose to resident 3.2. Review of resident 3's electronic medical record (EMR) revealed LPN F documented that resident 3 was administered 2.5 mL of morphine 2.5 orally, and the physician's order was for 0.25 mL. The director of nursing (DON), B, and Ecare were notified of the medication error. LPN F was instructed to monitor resident 3 and report any changes. Resident 3 was alert and responded initially to the staff after he was administered the morphine, but after twenty to thirty minutes after he began to have apnea (a temporary pause or stop in breathing). His vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits. A physician's order was received from the hospice nurse to administer Narcan. The facility's oncoming night nurse RN H, was notified of the medication error regarding resident 3 by LPN F, and the hospice nurse, RN N, came to the facility to assess the resident.No documentation in resident 3's EMR indicated vital signs were taken or if assessments were completed by LPN F after the incorrect dose of morphine was administered. There was no documentation of the time of day calls made to hospice or Ecare, no incident report completed to report the medication error, and no physician's order for the Narcan that was provided by Hospice. The verbal order for Narcan that LPN F received from RN N was not entered into the MAR with the corresponding ordering physician's name.3. Review of resident 3's EMR indicated that LPN F called ecare. CNA/MA E called DON B. Ecare then called hospice registered nurse (RN) N. RN N then called the facility back around 9:45 p.m. to check on how resident 3 was doing when she was made aware of his apnea, oxygen levels, and lethargy. RN N then called the facility back and gave LPN F a verbal order for Narcan.4. Interview on 5/27/26 at 3:00 p.m. with LPN F revealed that she did not know what time the events happened or when her assessments were completed on resident 3 after the medication administration error. She assessed the resident 5-10 minutes after the medication was given. She then left the hallway for 15-20 minutes to give another resident their medications leaving CMA E on the hallway to monitor the resident. LPN F stated I told her [CMA E] to stay with him and keep a close eye on him.5. Interview on 5/27/26 at 4:27 p.m. with MA E revealed she did give the 2.5 mL of Morphine to resident 3 on 5/14/26 and did not realize her error until going back to the medication administration record (MAR) to document the dosage. She said she normally double checks her doses but did not on that night. After MA E realized the error, she called DON B and told her, I made a significant medication error. MA E then went to find LPN F and DON B instructed LPN F to call Ecare. LPN F then called Ecare. Ecare then informed LPN F to watch resident 3 for drowsiness. Hospice RN N, then called the facility as they were notified of the error by Ecare to (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	inquire how resident 3 was doing. RN N told LPN F to monitor the resident.6. Interview on 5/28/26 at 1:25 p.m. with Hospice RN N revealed she gave instructions to LPN F to monitor resident 3 as the morphine would peak at 1 hour after administration. Hospice RN N then called the facility back after an hour and was told from either the MA or LPN that resident 3 was lethargic (more than usual), and his breathing was shallow with up to 20-second pauses, with oxygen saturation dropping into the mid to lower 80's. Hospice RN N then told the person on the phone that she was going to call the doctor for an order for Narcan. RN N then confirmed she went to the facility to assess resident 3. At that time, he had already received the Narcan. He was alert and able to talk. His only complaint was a dry mouth. RN N was in the facility for about forty-five minutes. Before leaving, she completed education with LPN H about Narcan and when she would be able to administer additional morphine if needed. That education was there were to be no additional narcotics given for 90 minutes.7. Interview on 5/28/26 at 3:45 p.m. with DON B revealed she considered resident 3's morphine incident a significant medication error. She expected that MA E would notify LPN F right away, and the nurse would complete a nursing assessment on the resident. She expected the nurse to assess and document, especially with a narcotic medication error, the resident's respiratory rate, blood pressure, pulse, oxygen, temperature, and orientation status, or how alert the resident was. She expected that the date and the time of the assessment being completed to be documented.8. Review of the provider's reviewed February 2025 Medication Administration policy revealed 3. medications must be administered in accordance with the orders, including any required time frame. 7. The individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time, and right route of administration before giving the medication.