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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to involve five of thirty (4, 9, 19, 44, and 59) sampled residents' primary care provider (PCP) in the development of the resident's advanced directives according to facility policy, failed to update one of five (44) sampled resident's electronic medical record (EMR) after the resident's code status had changed, failed to include one of five (59) sampled resident's code status on their care plan according to facility policy, and failed to make the resident's updated code status form available to direct care staff in the resident's EMR, which created potential confusion for staff when the most updated form was not available.Findings include:1. Review of resident 4's EMR revealed his code status was Do Not Resuscitate (DNR) on the top dashboard. His current care plan indicated his code status was DNR. There was no scanned document of his signed code status form in the Miscellaneous section, where scanned documents were stored. There was no documentation found anywhere in the EMR regarding the resident's code status.2. Review of resident 9's EMR revealed her code status was DNR on the top dashboard. Her current care plan indicated her code status was DNR. There was no scanned document of her signed code status form in the Miscellaneous section.3. Review of resident 19's EMR revealed his code status was DNR on the top dashboard. His current care plan indicated his code status was DNR. There was no scanned document of his signed code status form in the Miscellaneous section.4. Review of resident 44's EMR revealed his code status was DNR on the top of the dashboard. His current care plan included an intervention that read, I am a FULL CODE. That intervention was initiated on [DATE] and revised on [DATE]. The most recent code status form in the Miscellaneous section was from [DATE], which indicated that resident 44 wished to receive CPR (cardiopulmonary resuscitation) if he was in cardiac arrest (when the heart stops beating).5. Review of resident 59's EMR revealed her code status was DNR at the top of the dashboard. Her current care plan did not include her code status. There was no scanned document of her signed code status form in the Miscellaneous section.6. Interview on [DATE] at 1:56 p.m. with director of nursing (DON) B revealed that social services director (SSD) F was responsible for obtaining the resident's code status upon their admission to the facility. Their process was to have two staff members witness the resident or their representative sign the code status form. Then, SSD F was responsible to send the code status forms to the resident's PCP for review. The resident's PCP was supposed to sign the form and send it back to SSD F. Then, SSD F was supposed to scan the signed resident code status form into the resident's EMR.She provided copies of resident 4, 9, 19, 44, and 59's code status forms, and explained that they were in the Document Manager section of the resident's EMR, which was not available for staff or the survey team to review. She explained that none of the resident's code status forms were forwarded to the resident's PCP for review.7. Review of resident 4, 9, 19, 44, and 59's code status forms revealed that resident 4 signed his DNR choice on [DATE], resident 9 signed her DNR choice on [DATE], resident 19's representative signed his DNR choice on [DATE], resident 44 signed his DNR choice on [DATE], and resident 59's representative signed her DNR choice on [DATE]. There were no PCP signatures on any of the residents' code status forms.8. Interview on [DATE] at 8:43 a.m. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with SSD F revealed that at the time of a resident's admission, she had a conversation with the resident or their representative to explain what the advanced directives were, what a full code meant, and what a DNR meant. She typically had a witness present during that conversation, so two staff members witnessed the form being signed by the resident or their representative.They switched to a Document Manager electronic form management in their EMR. After the resident or their representative signed the electronic copy, she would forward that to the resident's PCP for final review and obtain their signature. She stated that some of the PCPs they work with will sign the code status form right away, while other PCPs preferred to have a conversation with the resident in person to verify their decision before signing the form.She confirmed that she was responsible for forwarding the resident's code status form to the resident's PCP. She said that the system is not perfect when speaking about the process of involving the resident's PCP. She confirmed that she did not involve resident 4, 9, 19, 44, and 59's PCP in the development of the resident's advanced directives. She forwarded those resident's code status forms to their respective PCPs on [DATE] during the survey. She confirmed that resident 4, 9, 44, and 59's PCP had signed the code status forms and sent them back on [DATE]. She was still waiting on resident 19's PCP to review, sign, and send back his code status form.9. Interview on [DATE] at 9:01 a.m. with licensed practical nurse (LPN) V and LPN J revealed that if a resident were found unresponsive, they would check the resident's code status at the top of the dashboard in the EMR before responding to the resident.When asked specifically about resident 44, LPN V went to his profile in the EMR and indicated that the resident's code status was DNR. When she clicked on the Advanced Directives link that was next to the DNR code status, it brought her to the Miscellaneous scanned documents portion. She pointed out that the most recent code status form (from [DATE]) available to her indicated that resident 44 was a Full Code. She would have gone by that form. She confirmed she did not have access to the Document Manager section of the EMR.10. Interview on [DATE] at 9:06 a.m. with LPN J revealed that she remembered when resident 44's code status was changed. She mentioned that SSD F was responsible for uploading the current code status form into the Document Manager section of the resident's EMR. She mentioned the Document Manager section was not available to the floor nurses, so they may not have the most updated information to respond if a resident had an event that required knowledge of their advanced directives.LPN J opened the resident care plan binder and pointed out that SSD F changed the paper copy of resident 44's care plan. She confirmed that the resident's electronic care plan had not been updated yet and still indicated that resident 44 was a full code. When asked which care plan version she would refer to, she indicated the electronic care plan.11. Interview on [DATE] at 9:19 a.m. with neighborhood leader (NL) W revealed that she was not aware the Document Manager portion of a resident's EMR was not available to the other staff members, like the floor nurses, certified nursing assistants, and certified medication aides.12. Interview on [DATE] at 12:25 p.m. with assistant DON (ADON) C revealed that they included a resident's code status on the resident's care plan. Each department had its respective section on the resident's care plan. The advanced directive section of the resident's care plan was maintained by SSD F.13. Interview on [DATE] at 12:28 p.m. with SSD F revealed that she was involved in developing the resident's care plan. She formulated the following sections: discharge planning, advanced directives, cognition, mood, and psychosocial well-being, and behaviors. The behaviors section was a collaborative effort with the nursing department.She confirmed that pretty much everyone will have an advanced directive section. She confirmed that she included the resident's code status on their care plan.She was not aware that resident 59's electronic care plan did not include her code status.She was aware that resident 44's electronic care plan was not updated after his code status changed to DNR on [DATE]. She explained that she hand-wrote the resident's code status change in the paper copy of the resident's care plan in the care plan binder on the unit. She usually updated the resident's electronic care plan each quarter with their Minimum Data Set (MDS) assessment. Resident 44's code status was changed after his [DATE] quarterly MDS assessment, so she had not updated the electronic care plan yet.14. Review (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the provider's 10/2025 Advance Directives policy revealed the policy statement read, Advance directives will be respected in accordance with state law and facility policy.7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.20. The Director of Nursing Services or designee will notify the Attending Physician of advance directives to that appropriate orders can be documented in the resident's medical record and plan of care.15. Review of the provider's 4/2025 Do Not Resuscitate Order policy revealed that the policy interpretation and implementation section included: 1. Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record.a. While awaiting the physician's order to withhold CPR, facility staff should immediately document discussion with the resident or resident representative, including, as appropriate, a resident's wish to refuse CPR. At a minimum, a verbal declination of CPR by a resident, or if applicable a resident's representative, should be witnessed by 2 staff members and documented in the resident's medical record. 2. A Do Not Resuscitate (DNR) order form must be completed and signed by the attending physician and resident (or resident's legal surrogate, as permitted by state law) and placed in the resident's medical record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to follow their policy and provide the necessary respiratory care and services for four of four sampled residents (4, 8, 10, and 49), resulting in inadequate storage, humidification, and replacement of those devices.Findings include:1. Observation and interview on 12/16/25 at 10:45 a.m. with resident 49 in her room revealed:*She was sitting in her recliner chair.*She had an oxygen concentrator machine (a machine that filters room air into pure oxygen and then delivers it through a tube with prongs that fit in the nostrils or a mask) next to the foot of her bed.*She had oxygen nasal cannula tubing (tubing that delivers oxygen through the nose) stored on top of the concentrator.-The tubing was not dated, and there was no storage bag or other container to hold the tubing when it was not in use.*A nebulizer machine (a medical device that turns liquid medicine into a mist that is then inhaled into the lungs through a mask or mouthpiece) was sitting on the floor between her two recliner chairs.*The nebulizer tubing and mask were attached to the nebulizer machine and were not dated.*The nebulizer tubing and mask were then draped over the right arm of the light green recliner.*The nebulizer mask rested on a pink plush blanket that was in the chair.-The nebulizer machine and mask were not stored on a clean barrier to protect them from potential contamination. Review of resident 49's electronic medical record (EMR) revealed:*She was admitted on [DATE].*She was diagnosed with chronic obstructive pulmonary disease (COPD).*She had an order for oxygen via nasal cannula as needed to keep oxygen saturation greater than 90 percent.-That order started on 6/26/24.*There was no documentation on her electronic medication/treatment administration record (EMAR/ETAR) for December 2025, indicating she used oxygen.*There were no physician or nursing orders to change the humidification bottle on the oxygen concentrator or the oxygen tubing on a scheduled basis. *There were no physician or nursing orders to change the nebulizer tubing or replace the mask on a scheduled basis. 2. Observation and interview on 12/16/25 at 11:18 a.m. with resident 4 in his room revealed he had an oxygen concentrator machine next to his bed. There were no markings on the oxygen tubing or the humidifier bottle to indicate when those were last changed. He said that he used the oxygen machine when he first admitted to the facility on [DATE] but had not used it in a long time. Review of resident 4's electronic medical record (EMR) revealed he had a physician's order for Oxygen via [nasal cannula] as needed to keep oxygen saturation [greater than 90 percent]. That order was started on 11/18/25. There were no physician's or nursing orders to change the humidifier bottle or oxygen tubing on a scheduled basis. The last time it was documented that the resident used the oxygen concentrator machine was on 11/19/25, when his blood oxygen concentration was measured at 95 percent Oxygen via Nasal Cannula. 3. Observation on 12/16/25 at 2:05 p.m. of resident 8 in her room revealed*She was lying in her bed and wearing oxygen via a nasal cannula.*She had an oxygen concentrator machine next to her bed that was running and set at 4 liters.*There was a humidification bottle connected to the concentrator.-The connection tube, humidification bottle, and nasal cannula tubing were not dated.*She had a nebulizer machine on top of the wooden dresser, and the nebulizer tubing was wrapped around the machine.*The nebulizer tubing was not dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 8's EMR revealed:*She was admitted on [DATE].*She was diagnosed with hypoxia (low oxygen levels in the blood).*She had an order for oxygen via nasal cannula as needed to keep oxygen saturation greater than 90 percent.-That order started on 12/21/20.*She had an order that oxygen may be titrated from 1 liter up to 5 liters to maintain oxygen saturation greater than 90 percent or above every shift.-That order started on 12/1/25.*It was documented that she wore the oxygen every shift.*There were no physician or nursing orders to change the humidification bottle or the tubing on a scheduled basis. *There were no physician or nursing orders to change the nebulizer tubing or replace the mask on a scheduled basis. 4. Observation on 12/16/25 at 3:19 p.m. in resident 10's room revealed:*He had an oxygen concentrator machine next to his bed.*There was a humidification bottle connected to the concentrator.-The connection tubing that connected the humidification bottle to the concentrator was dated 10/26.-The humidification bottle was not dated.*He had a continuous positive airway pressure (CPAP) machine (a machine to treat sleep-related breathing issues) on top of the dresser next to the bed.-The oxygen tubing on the concentrator that connected to the CPAP was dated 10/26.*The oxygen tubing was on the floor, and there was no storage bag or other container to hold the tubing when it was not in use to protect it from potential contamination. Review of resident 10's EMR revealed:*He was admitted on [DATE].*He was diagnosed with obstructive sleep apnea (a sleep disorder where breathing repeatedly stops and starts during sleep) and acute respiratory failure with hypoxia (low oxygen levels in the blood).*He had an order to wear the CPAP per home settings at night. -That order started on 4/24/24.*It was documented that he wore the CPAP every night.*He had an order for oxygen via nasal cannula as needed to keep oxygen saturation greater than 90 percent.-That order started 9/17/25.*There were no physician or nursing orders to change the humidification bottle or the oxygen tubing for his concentrator and CPAP on a scheduled basis. 5. Interview on 12/17/25 at 9:50 a.m. with registered nurse (RN) G regarding respiratory equipment in resident 10's room revealed:*She was unsure if the oxygen tubing residents used was changed every two weeks or once a month.*She stated that the oxygen tubing should be dated and stored in a bag when it was not in use.*Oxygen tubing was to be replaced by the night shift when the task was generated on the resident's EMAR/ETAR.*She stated that staff received annual oxygen training that was offered in the spring and fall.*She confirmed that resident 10's oxygen and connection tubing were dated 10/26.*She agreed that it had not been changed in over a month and removed the tubing. 6. Interview on 12/17/25 at 10:08 a.m. with RN/neighborhood leader H revealed:*She stated oxygen tubing for residents was to be changed every two weeks, dated, and possibly initialed by the staff who changed the tubing.*Oxygen tubing was to be in a storage bag when it was not in use to protect it from potential contamination.*She stated that the humidification bottles on the oxygen concentrators were to be changed on the same schedule as the oxygen tubing. 7. Interview on 12/17/25 at 10:42 a.m. with RN/neighborhood leader I revealed:*She was unsure when oxygen and nebulizer tubing for residents were to be changed. 8. Interview on 12/17/25 at 10:51 a.m. with director of nursing (DON) B revealed:*She stated that the residents' oxygen tubing was to be replaced twice monthly, and the nebulizer tubing and the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mask/pipe were to be replaced every seven days according to their policy.-All oxygen and nebulizer tubing and supplies were to be dated and initialed by the staff when they were changed.*The night shift nursing staff were primarily responsible for the task of replacing the oxygen and nebulizer tubing as scheduled, but on occasion, this task could be assigned to the day shift nursing staff to complete. *There was to be a storage bag for the oxygen tubing to be stored in when it was not in use, and it was to be dated and initialed by the staff who changed it.*She stated staff were expected to place a clean barrier for the storage of the nebulizer mask/pipe to be stored on when not in use. *It was her expectation that nebulizer machines should not be stored on floors because dirty floors were a potential source of infection.*It was her expectation that oxygen tubing should be replaced twice a month and nebulizer tubing should be replaced once a week. -The supplies should be dated, initialed by staff who changed them, and appropriately stored. Review of the providers reviewed 10/25 Oxygen Administration policy revealed:*Preparation:-1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.*Steps in the Procedure:*Cleaning Schedule:-1. Oxygen tubing and humidifier: changed the 1st and the 15th of the month and as needed along with the storage bag.-2. Oxygen tubing, humidifier, and storage bag should be dated and initialed when changed. Review of the providers reviewed 12/25 Administering Medications through a Small Volume (Handheld) Nebulizer policy revealed:*Preparation:-1. Obtain a physician's order as needed.- .17. Rinse the nebulizer equipment according to facility protocol, or:--a. wash pieces with warm, soapy water;--b. rinse with hot water;--c. allow to air dry on a paper towel or in nebulizer drying bags.- .19. Change equipment, tubing, and drying bag every seven days. Equipment should be dated and initialed when changed.-20. Disinfect outside of the Nebulizer Machine between residents, according to manufacturer's instructions.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to:*Maintain food safety requirements related to one of one Maple Valley neighborhood pantry room, and one of one Maple Valley kitchenette. *Maintain clean and sanitary conditions for three of three foodservice handwashing sinks in the [NAME] Creek neighborhood.*Implement interventions to supervise and monitor resident refrigerator temperatures to identify any hazards of foodborne illness for two of two observed residents (17 and 24).Findings include:1. Observation on 12/16/25 at 9:47 a.m. of the Maple Valley neighborhood food service pantry revealed:*A wheeled cart was inside that room. Clean drinking cups, coffee mugs, silverware wrapped in napkins, a water pitcher, and a plate guard sat on a towel on top of that cart. One end of the cart had openings for pushing the cart. There were multiple, dried white-colored runs down the inside lip of that end of the cart near the edge of the towel and by the clean kitchenware. The clean kitchenware was not stored in a way that would mitigate contamination.*There were two wire shelving units inside that pantry room. A Clean sign hung on the front of and below the top shelf of the first unit. A sign next to the first sign read All dishes placed on this rack must be faced down and on a tray. It was unclear if those signs applied to the items on the top shelf, the second shelf, or both shelves. The following items were not stored in a manner to protect them from becoming contaminated:-A rolling pin and muffin tin sat directly on the top shelf. There was an opened plastic bag of Styrofoam food storage boxes, also on the shelf.-A lidded plastic cup with a flexible straw, stacked bowls, a plastic water pitcher, a plastic measuring cup, insulated lids, plastic cups, and other miscellaneous kitchen items sat directly on the second shelf. *On top of a dorm-sized freezer next to the above shelving unit were measuring cups, bowls, a water pitcher, a food thickening dispenser, and a plastic-covered pan of dessert. *The second wire shelving unit was directly across from the first. Hanging from the second shelf of that unit was a Dirty sign. Sitting directly on that same shelf, there were stacks of folded clean dish rags. -To the right of the rags was a Styrofoam cup lid lying directly on the shelf, and an open sleeve of the same type of lids. Behind that, a small stack of Styrofoam food containers and plates lay directly on the shelf.-To the left of the dish rags was an open sleeve of Styrofoam cups. In front of that bag were several plastic forks lying directly on the shelf. A spray bottle containing sanitizer hung off the shelf next to that. Behind that was an opened box with plastic spoons and Styrofoam cups inside it. *On the bottom shelf, a baking sheet lay directly on top of that shelf. A plastic fork sat on top of the sheet. There were Styrofoam plates and plastic lids next to a bottle of Goof-Off (latex paint and adhesive remover) and a gallon-size jug of dish soap next to it. Behind those cleaning supplies were multiple used flower vases. 2. Continued observation of the Maple Valley neighborhood kitchenette area revealed:*Inside the cabinet next to the steam table, Styrofoam bowls, plates, canned soup, and snacks were stored. The inside of those cabinet doors appeared to be coffee-stained. Two of the shelves inside that same cabinet appeared to be coffee-stained. *Inside the top drawer beside the stove were two soiled oven mitts and a pair of scissors stored with a spatula and a set of tongs. 3. Observation and interview on 12/16/25 at 10:26 a.m. with resident 17 in his room of the Cottonwood Court neighborhood revealed: *He had a personal refrigerator in his room. *He mentioned that his children were responsible for cleaning and disposing of expired food items. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He said staff would check the temperature of his refrigerator approximately once a week. *The refrigerator was mildly dirty, with small food particles observed on the shelves and inside the door. *The freezer section had a moderate buildup of frost and ice. *There was a small opened jar of strawberry jam, an opened squeeze-bottle of Miracle Whip salad dressing, an opened container of French onion dip, and an opened package of sliced cheese stored in the door of the refrigerator. *There was no temperature log located on or near the refrigerator. *There was no thermometer in the refrigerator to know the current temperature of it. 4. Interview on 12/16 at 3:45 p.m. with certified nurse aide/unlicensed medication aide (CNA/UMA) AA inside the Maple Valley pantry revealed that the cart holding the clean dinnerware remained in that room. She agreed that the cart was unclean, but she had not known who was responsible for cleaning it. She thought the Dirty sign on the second shelving unit should have been removed. She had not known who was responsible for organizing and keeping the pantry room clean. Items in the pantry and kitchenette should have stored or covered in a manner to protect them from potential contamination. 5. Interview on 12/16/25 at 4:10 p.m. with director of nursing (DON) B in the Maple Valley pantry and kitchenette revealed that a combined effort between nursing staff and dietary staff was expected to maintain the pantry and the kitchenette cleanly and safely for food service and cookware. There was nothing for those staff to refer to for them to know the expectations for maintaining the pantry and kitchenette cleanly and safely, who was responsible for what tasks to maintain those areas, or how frequently it was expected that those tasks occurred though. She agreed that based on the above observations, the pantry and kitchenette had not been maintained in a manner to keep it organized, clean, and sanitary for food service. 6. Interview on 12/16/25 at 4:00 p.m. with dietary manager (DM) D regarding the Maple Valley pantry and kitchenette revealed that nursing staff were responsible for maintaining those areas. Nursing staff were also responsible for returning the carts with dirty dishes to the kitchen for cleaning. Dietary staff were responsible for returning the cleaned carts to the neighborhood. 7. Observation and interview on 12/16/25 at 4:30 p.m. with resident 24 in his room of the [NAME] neighborhood revealed: *He had a personal refrigerator in his room. *He said that his children were responsible for cleaning and disposing of expired food items. *He was unsure if the staff checked the temperature of the refrigerator daily. *There was an open package of potato lefse (a soft flatbread made from riced potatoes, flour, butter, and cream or milk) stored on a shelf in the refrigerator. *There was no temperature log located on or near the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*There was no thermometer in the refrigerator to know the current temperature of it. 8. Observation on 12/17/25 at 8:06 a.m. in the [NAME] Creek neighborhood pantry room behind the kitchenette revealed the handwashing sink had unidentified food scraps that appeared to have been tomato skins stuck to the drain catch. 9. Observation on 12/17/25 at 9:55 a.m. in the [NAME] Creek dining room revealed the handwashing sink next to the beverage dispensers was stained with what appeared to be coffee or brown-colored rust. 10. Interview on 12/17/25 at 10:35 a.m. with registered nurse (RN) G revealed: *She stated resident families were responsible for the residents' personal refrigerators. *The nursing staff was not responsible for the resident refrigerators. 11. Interview on 12/17/25 at 10:43 a.m. with RN/neighborhood leader H revealed: *She stated that residents and resident families were responsible for cleaning, disposing of outdated food items, and checking the temperatures of the refrigerators. *The nursing staff was not responsible for the resident refrigerators. 12. Interview on 12/17/25 at 11:03 a.m. with director of nursing (DON) B revealed: *She stated that residents and families were notified and given the information about personal refrigerators upon admission or as they had requested. *She stated that residents and families were responsible for cleaning and disposing of outdated food items on a routine basis. *She indicated housekeeping was responsible for checking the residents' refrigerator temperatures daily and maintaining the logs of those temperatures. *She confirmed that resident refrigerators should have had a thermometer in them and that it was the responsibility of the facility to have one for each resident refrigerator. *The refrigerator temperatures should have been maintained between 36 and 46 degrees Fahrenheit (F) for food safety. *She agreed that to avoid a hazardous foodborne illness, resident refrigerators should have been checked daily for appropriate temperatures. *It was her expectation that the temperatures for the refrigerators in resident rooms were checked and documented daily by housekeeping. 13. Interview on 12/17/25 at 11:43 a.m. with maintenance supervisor E revealed: *He was asked to provide the residents' refrigerator temperature logs for the past two months. -He stated that the previous maintenance supervisor and housekeeping had not maintained the (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident refrigerator temperature logs. *He stated that he was unaware that the refrigerator temperatures in residents' rooms needed to be checked daily. *He stated that the housekeepers did not know and were not told or educated to check the resident refrigerator temperatures daily. *He confirmed that no resident refrigerator temperatures had been completed, and no logs had been maintained for those refrigerators. *He agreed that to avoid a hazardous foodborne illness, temperatures in resident refrigerators should be checked and documented daily to ensure they were in the appropriate temperature range for food safety. 14. Interview on 12/17/25 at 1:51 p.m. with housekeeping P revealed: *She stated that she had not checked or documented any resident refrigerator temperatures. *She indicated that she had not been told or educated to perform that housekeeping task. 15. Interview on 12/18/25 at 10:50 a.m. with DM D and DON B revealed that the nursing and housekeeping departments were responsible for cleaning the handwashing sinks on the resident neighborhoods. DM D said that food and beverages were not supposed to be poured down the handwashing sinks in those areas. 16. Interview on 12/18/25 at 10:55 a.m. with CNA L revealed that the CNAs cleaned the tables and counters after each meal. She was not sure who was responsible for cleaning the handwashing sinks in the dining room, in the kitchenette, or in the pantry room. She did not know if there was a cleaning checklist or not. 17. Interview on 12/18/25 at 10:57 a.m. with licensed practical nurse (LPN) J revealed that she thought that there was a cleaning checklist for the CNAs for the kitchenette and dining room areas. She looked through several binders in the kitchenette and nursing station cupboards, but she could not find a cleaning checklist for them. 18. Observation on 12/18/25 at 10:59 a.m. in the [NAME] Creek kitchenette revealed there were food scraps and coffee grounds in the handwashing sink located to the right of the oven. The unidentified food scraps that appeared to have been tomato skins (from the observation on 12/17/25 at 8:06 a.m.) were still present in the handwashing sink located in the pantry room. 19. Interview on 12/18/25 at 11:02 a.m. with housekeeper Q revealed that she gave conflicting responses when asked if the housekeeping staff were responsible for cleaning the handwashing sinks in the resident neighborhoods. She at first said that she cleaned them every day, but then she said she cleaned them once per week. She said she does not clean the handwashing sink in the pantry room located behind the kitchenette. 20. Interview on 12/18/25 at 11:57 a.m. with administrator A revealed he expected staff to refrain from pouring food and beverages down the handwashing sinks. He explained that it was the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	housekeeping staff's duty to perform regular cleaning of the resident areas like the dining room, kitchenette, the beverage station, and the handwashing sinks. Review of the providers reviewed 8/2025 Resident Refrigerator policy revealed: *Policy: - C. Nursing will obtain the thermometer from dietary which will be placed in the refrigerator. -D. Housekeeping checks the temperature of the fridge in resident's room. -E. Resident/family will ensure that all food placed in the refrigerator is covered. After opening the container, it is to be used or removed within an acceptable time frame. -F. The refrigerator is to be cleaned by the family member. -G. Housekeeping staff will check to ensure the resident or family member is removing and disposing of open items and keeping the refrigerator clean. -.I. If the resident or family member is unable to maintain the refrigerator according to the policy/procedure, staff will advise the family that it will have to be removed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to:*Ensure staff members followed proper storage and cleaning procedures for both clean and dirty utility rooms in two of the four facility neighborhoods ([NAME] Creek and [NAME] Wood) to prevent the spread of infection.*Discard products found in one of four resident neighborhoods, such as hand sanitizer and germicidal (germ-killing) wipes, on or before the expiration date which had the potential to affect all people in the facility.Findings include:1. Observation on [DATE] at 2:03 p.m. in the common area outside the beauty/barber shop revealed an automatic hand sanitizer dispenser on the wall. The hand sanitizer had expired on [DATE]. 2. Observation on [DATE] between 2:16 p.m. and 2:24 p.m. in the soiled utility room of the [NAME] Creek neighborhood revealed: *A four-product disinfectant dispensing system that was mounted inside the door on the left wall with black and white discharge tubes and hoses connected to dispense the chemicals. *An unconnected, black discharge hose, approximately five feet long, was coiled up and lying in the bottom of the drain tub. *The caulking around the drain tub had a black substance coating it. *There was a stainless steel two-compartment sink with counterspace cluttered with chemicals, glass jars, vases, and a pink basin of items. *One compartment of the sink contained a white bucket with dirty water that had a white film on the top. *The counter space on the left side of the sink contained two opened containers of Micro-Kill disinfectant. -The lids were off and faced down, lying on the countertop next to a dirty micro-fiber rag and a blue writing pen. *The right side of the counter space contained three empty glass jars and one empty glass flower vase. *The right side of the counter space contained a pink basin that held a container of Lime-Away, a spray bottle of Clorox Urine Remover, a plastic bag that contained instructions for the splash guard (a shield to prevent splashing by blocking liquid waste and protecting workers), and a soiled blue and white sponge. *Four floor tiles under the left side counter space of the sink had a dry white film substance on them. *An empty cardboard box was on the floor near the left side of the sink. *There were three empty clothes baskets on the floor under the right side of the counter space. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The soiled hopper sink (a plumbing fixture that safely disposes of liquid or semi-solid biological waste) was missing the splash guard. -The splash guard was lying on the floor between the hopper and the hand-washing sink. *The rinse hose was hanging from the holder and submerged in the dirty water of the hopper sink. *The hopper sink had a strip of black sticky material approximately ten inches long that ran along the front edge, where the splash guard had once been attached. *There were no gowns, gloves, or goggles available near the hopper for staff use. *Areas of the floor were visibly soiled with dirt, lint, and dust fibers. 3. Observation on [DATE] between 2:25 p.m. and 2:34 p.m. in the clean utility room of the [NAME] Creek neighborhood revealed: *A sign posted on the door read: CLEAN UTILITY ROOM: ONLY ITEMS THAT ARE CLEAN OR HAVE BEEN CLEANED CAN BE IN HERE. *On the floor just inside the door, along the left wall, was an oxygen concentrator machine that appeared dirty. *It had a humidification bottle that contained approximately 1/3 of water and a connection tube attached. *There was a black wire storage container on the floor that had a gray bin, and a black wall-mount clock stored in it. *There were two large boxes and two small boxes of Halloween decorations stacked on top of two white laundry baskets stored on the floor. *On the floor just inside the door, along the right wall, there was a white three-drawer bin, and the drawers were visibly dirty with lint, material fibers, and dirt. *There were four large white clothes baskets stacked on top of each other and stored on the floor next to the three-drawer bin. *There was a large opened cardboard box on the floor that contained yellow disposable gowns, boxes of N95 respirator masks, and clear plastic mountable file holders. *There was a tall wooden stand with four visibly dusty compartments stored on the floor, and a nebulizer machine that appeared dirty stored on top of it. *On the floor was a large box with Halloween and fall decorations, with a large, clear garbage bag of fall decorations stored on top of it. *The left countertop next to the sink stored two unopened cardboard boxes of hand soap, two unopened boxes, and one opened box of N95 respirator masks, which could have become wet if (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	someone washed their hands at the sink. 4. Observation on [DATE] between 2:35 p.m. and 2:45 p.m. in the soiled utility room of [NAME] neighborhood revealed: *A four-product disinfectant dispensing system that was mounted inside the door on the right wall with black and white discharge tubes and hoses connected to dispense the chemicals. *An opened multi-surface disinfectant container was stored on the floor in front of the drain sink. -The disinfectant had one end of a white discharge tube placed into the opening of the black lid, while the other end of the discharge tube was lying on the visibly soiled floor next to the drain sink. *The caulking around the drain tub had a black substance coating it. *A yellow mop bucket that appeared dirty was stored in the drain sink. *A clear discharge hose, stained brown, contained brown and black residue on the inside of the tube and was coiled around the cold-water faucet handle. *The wall behind the drain sink was coated in dirt and a layer of brown film. *A tan wheeled cart cluttered with paint supplies was placed just inside the door, which blocked the entrance and needed to be moved to access the room. *There was a stainless steel two-compartment sink with counter space cluttered with various items and chemicals. *The right side of the counter space contained five opened containers of cleaning chemicals. -The spray nozzle for the opened container of multi-surface peroxide was stored next to it. *There was a large black bucket in one sink compartment that contained used paint rollers and supplies with water that had formed a milky-gray film on top. *A visibly soiled white bath towel was draped over the right edge of the sink. *The left side of the counter space was blocked by a cupboard door approximately four feet tall and a large black and yellow wheeled floor cleaning machine. *The stainless steel two-compartment sink with counterspace contained a white bucket with dirty water in one compartment of the sink that had a white film that formed on top of the water. *The soiled hopper sink was missing the splash guard, and it was lying on the floor up against the wall next to a black trash bag. -The hopper sink had a paint pan with dried paint stored on top of it. *The hopper sink had a strip of black sticky material approximately ten inches long that ran along the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Between the two walls, adjoined a countertop with a sink and cupboards that were blocked with opened and unopened cardboard boxes of supplies on the floor. *Some opened cardboard boxes contained toilet paper, hand soap, and chemicals. *The countertop sink and cupboards were also blocked by a black three-shelf cart on wheels that had a piece of masking tape posted on the middle shelf that read: MAINTENANCE. *The black wheeled cart was cluttered with cans of paint, green hose, cardboard boxes, a pink bin that stored light bulbs, and other unidentified maintenance supplies. *The countertops next to the sink were cluttered with used paint supplies and other items. *The left countertop stored used paint brushes, paint sticks, paint cans, rollers, roller handles, plastic bags, chemicals, a spray bottle of paint, a package of peri-wipes, and a large box of trash liners. *The right countertop stored used paint containers, paint sticks, paint pans, and a stack of white paint sheets. *The sink contained used paint pans and containers with dirty paint supplies stored in them. -The sink and the wall behind the sink were soiled with dried tan paint and covered with a white film. *There was trash, cardboard, and empty spray bottles on the floor. *The floor was visibly soiled with dirt, lint, and paint fibers. 8. Observation on [DATE] at 2:54 p.m. in the dirty utility room on the [NAME] Creek neighborhood revealed that the protective shield for the hopper (a type of flushing sink with a spray hose nozzle used for rinsing soiled laundry prior to washing) was not attached. It was sitting on the floor underneath the handwashing sink. There was no personal protective equipment (PPE), such as aprons, face shields, and gloves, available in the dirty utility room for staff to use if they needed to rinse soiled laundry. 9. Observation on [DATE] at 2:54 p.m. in the [NAME] Creek neighborhood clean utility closet revealed there were at least two containers of germicidal wipes that were expired. One container of Micro-Kill Bleach wipes were open to air and the wipes were dry. That expiration date was [DATE]. Another container of SANI-CLOTH BLEACH wipes was also open to air and dry, with an expiration date of 03/2024. 10. Observation and interview on [DATE], starting at 3:00 p.m. with assistant director of nursing (ADON) C in the clean and soiled utility rooms of [NAME] Creek and [NAME] neighborhoods revealed: *She stated it was the maintenance and housekeeping's responsibility to maintain and keep those areas organized and clean. *She confirmed that the clean and soiled utility rooms in both neighborhoods were cluttered, unkept, and could pose safety risks for staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She expected that all utility rooms in the neighborhoods should be organized, well-maintained, and cleaned by the maintenance and housekeeping departments. 11. Observation on [DATE] at 3:01 p.m. in the [NAME] Creek neighborhood dry storage room revealed several cases of the green aloe hand sanitizer that had an expiration date of [DATE]. There were other various partially used bottles of hand sanitizer that had all expired over a year ago. 12. Observation on [DATE] at 3:07 p.m. in the hallway between the [NAME] Creek neighborhood clean utility, dirty utility, and dry storage rooms revealed there was a plastic set of drawers. It appeared to have been a transmission-based precaution supply kit that contained personal protective equipment and signage for enhanced barrier precautions. There was a container of Micro Kill AF2 wipes with a Best By date of [DATE]. 13. Observation on [DATE] at 9:46 a.m. in the kitchen revealed there were at least two bottles of green aloe hand sanitizer, one with an expiration date of [DATE], and the other with an expiration date of [DATE]. 14. Interview on [DATE] at 3:24 p.m. with ADON C revealed that the automatic hand sanitizer dispensers were managed by the maintenance department. She said, I would like to tell you there's a process for checking expiration dates, but there isn't one. She confirmed there was no set process to check the expiration dates on the hand sanitizers or germicidal wipes. She was not aware of the expired hand sanitizer bottles throughout the [NAME] Creek neighborhood. She expected staff to check the product dates before using it, and to discard the product and find a replacement if the product was expired. 15. Interview on [DATE] at 10:57 a.m. with maintenance supervisor E and housekeeping O revealed: *They both agreed and confirmed that the clean and soiled utility rooms in both neighborhoods were cluttered, unkept, and could pose safety risks for staff. *They both agreed that it was the maintenance and housekeeping staff's responsibility to keep those areas maintained, organized, and clean. 16. Interview on [DATE] at 11:18 a.m. with director of nursing (DON) B revealed: *She stated it was the maintenance and housekeeping's responsibility to maintain and keep resident rooms and all facility areas organized and clean. *She expected that all resident rooms and utility rooms in the neighborhoods should be organized, well-maintained, and cleaned by the maintenance and housekeeping departments. Review of the provider's [DATE] Infection Prevention and Control Committee policy revealed:*1. The objectives of the infection prevention and control program (IPCC) are to:-.b. provide facility guidelines for a safe and sanitary environment;-c. review, establish, and monitor environmental infection prevention and control practices in accordance with CDC/HICPAC/OSHA guidelines and local or state requirements;*.8. Assist in monitoring and assessing facility-wide environmental infection prevention and control practices.*.13. Collaborate with environmental services director to establish policies and procedures that are consistent with environmental infection prevention and control best practices.*Risk Exposure Categories: The infection prevention and control committee shall advise the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (19), who had a medication pill at his bedside, was assessed for the ability to safely self-administer medications and had a physician's order to self-administer medications according to the provider's policy.Findings include:1. Observation and interview on 12/16/25 at 4:12 p.m. with resident 19 in his room revealed there was a small white oval pill in a plastic medication cup sitting on his bedside table. The pill had 0164 stamped on one side, and the letter R stamped above the number 5 on the other side. Resident 19 said that if he is sleeping, staff would leave his pills on his bedside table so he could take them later. He swallowed the medication at that time with a drink of water.2. Review of resident 19's electronic medical record (EMR) revealed that he was admitted to the facility on [DATE]. He did not have a physician's order to self-administer any medications. There was no record of medication self-administration assessments. His current care plan did not include any medications that he could self-administer.3. Interview on 12/17/25 at 10:00 a.m. with certified nursing assistant (CNA) L revealed that she was also a certified medication aide (CMA). Resident 19 was independent with activities of daily living (ADLs) such as getting up from his bed, walking, brushing his teeth, and changing clothes. She did not know if he had an order for medication self-administration. She explained that sometimes, resident 19 would become upset if staff stood there to watch him take his medications.She confirmed that if a resident did not have an order to administer their medications by themselves, staff were to observe the resident take their medications rather than leave the medications with the resident.4. Interview on 12/17/25 at 10:13 a.m. with neighborhood leader (NL) W revealed that she confirmed that resident 19 did not have an order for medication self-administration. She confirmed that at around the time the pill was found on 12/16, resident 19 would have been given his olanzapine (an atypical antipsychotic medication).NL W unlocked the medication cart and confirmed the small white oval pill with 0164 stamped on one side, and the letter R stamped above the number 5 on the other side was resident 19's olanzapine.She expected the licensed nurses and CMAs to watch the resident take their medications if the resident did not have an order to self-administer their medications. She stated that if a resident wanted to self-administer their own medications, the nurse and resident would complete a medication self-administration assessment, contact the physician, and update the resident's orders.Continued interview on 12/17/25 at 10:40 a.m. with NL W revealed that she contacted the nurse who was working on 12/16/25. That nurse said that she thought she saw him take the pill, so she did not know why the pill was still in the medication cup when it was observed by the survey team on 12/16/25 at 4:12 p.m. that day.5. Interview on 12/17/25 at 3:32 p.m. with assistant director of nursing (ADON) C revealed that resident 19's medications should not have been left in his room. The person administering his medications should have observed resident 19 take his medications and ensured that he actually took them. She confirmed that resident 19 had not been assessed to take his medications by himself, and he did not have a physician's order for medication self-administration.6. Interview on 12/17/25 at 4:00 p.m. with director of nursing (DON) B revealed that if a resident did not have an order for medication self-administration, the staff person administering the medications should be observing the resident take their medications.She confirmed that resident 19 did not have an order to self-administer his medications.She explained that if a resident wished to self-administer their medications, the nurse assessed the resident's cognition and filled out the Self-Administration of Medications form. That form consisted of quizzing the resident on what each medication was, what was it prescribed for, what the potential side effects were, what the dosage was, what route was it to be administered, and what time it should be administered. If the resident could not confidently list each topic for the medication, they could not safely self-administer their own medications.7. Review of the provider's 1/2025 Self-Administration of Medications policy revealed that the policy (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interpretation and implementation section contained the following items: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 2. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident:a. The medication is appropriate for self-administration;b. The resident is able to read and understand medication labels;c. The resident can follow directions and tell time to know when to take the medication;d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; ande. The resident is able to safely and securely store the medication. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re-assessed periodically based on changes in the resident's medical and/or decision-making status. 4. If the team determines that a resident cannot safely self-administer medications, the nursing staff [will] administer the resident's medications.6. Self-administered medications are stored in a safe and secure place. 7. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and policy review, the provider failed to maintain resident rooms in a clean and well-kept manner, free from damage to walls, for two of two sampled residents (10 and 17) in one of four facility neighborhoods (Cottonwood Court).Findings include:1. Observation on 12/16/25 at 10:16 a.m. in resident 10's room and interview on 12/17/25 at 11:50 a.m. with resident 10 in a resident common area between the neighborhoods revealed:*There were at least three gouges with chipped paint, which were approximately quarter-size, and a gouge with exposed drywall about half-dollar size, in the left wall, between two to three feet above the floor, just inside the resident's door. Additionally, there were vertical scratch marks with chipped paint along the entire length of the left wall. *There were at least three gouges with chipped paint that ranged from one to four inches in size, and vertical scratch marks with chipped paint on the wall to the right, just outside of his bathroom. Additionally, there were vertical scratch marks with chipped paint on the bathroom door frame. *There was a vertical gouge in the wall behind his oxygen concentrator (a machine that takes room air and delivers pure oxygen through a nasal cannula or mask) that was approximately six inches in size.*Along the baseboard beneath his window, there was a vertical gouge about five inches long with exposed drywall and chipped paint. Additionally, there were at least 12 gouges, ranging from the size of a pencil eraser to a dime, along with vertical scratch marks and chipped paint that extended for most of the wall's length. *The resident stated that he accidentally caused the big gauges in the walls when he caught his electric wheelchair on the bed, which caused the bed to hit the wall.*The resident stated that the minor gouges and scratch marks were caused by him moving his electric wheelchair too close to the walls. 2. Observation and interview on 12/16/25 at 10:26 a.m. in resident 17's room revealed:*There were at least six gouges with chipped paint, each about the size of a pencil eraser, and a vertical gouge with chipped paint, approximately two inches long, in the left wall, about two feet above the floor, just inside the resident's door. Additionally, there were vertical scratch marks with chipped paint along the entire length of the left wall. *Along the baseboard of that same wall, there were at least three additional gouges with chipped paint that ranged from dime to quarter size, and vertical scratch marks with chipped paint. *There were at least nine gouges with chipped paint that ranged from a pencil eraser to quarter-size in the right wall, about two feet above the floor, just inside the resident's door.*There were four vertical gouges with exposed drywall on the wall between the resident's bed and his three-drawer wood dresser, approximately three to six inches in size. *There was a hole with exposed drywall and chipped paint in the wall behind the resident's bed, approximately the size of a football.*The resident stated that he caused the damage to the walls by accidentally running his electric wheelchair into them, or when he had maneuvered it too close to the walls. 3. Interview on 12/18/2025 at 10:20 a.m. with registered nurse (RN) G revealed:*Staff were to complete a maintenance request form when they needed something repaired in the facility. *The forms were located on the wall outside the maintenance room door.*She stated that the maintenance office was located in the [NAME] neighborhood. *She stated that maintenance staff had applied bumpers to residents' beds and placed sandbags behind resident recliner chairs to help prevent damage to the walls.*She stated maintenance staff responded pretty quickly to the request forms completed by staff. 4. Interview on 12/18/2025 at 10:32 a.m. with certified nursing assistant/certified medication aide (CNA/CMA) M revealed:*Staff were to complete a maintenance request form and turn it into the maintenance box when something needed to be repaired in the facility. *She said that staff could call the maintenance staff with an issue, but they would also be asked to fill out a repair form for it. *She stated that the maintenance staff responded quickly to things that needed to be repaired. 5. Interview on 12/18/2025 at 10:57 a.m. with maintenance supervisor E and housekeeping O revealed: *The request/repair requisition forms for maintenance-related work requests were stored in a box attached to the wall in the hall, next to the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintenance office door, labeled work order forms.*Staff members were to complete a form if something required a repair and put the completed form in the box with the slot labeled repair requests. *Request forms for repairs were addressed promptly by maintenance staff to ensure the most critical issues were addressed first to maintain resident safety. *Housekeeping O stated that it was hard to repair damaged walls in resident rooms when residents were in their rooms.*Maintenance supervisor E stated that discussions with management had been held to apply bumper pads on walls to help prevent damage in the residents' rooms.*They both clarified that they were aware of the damaged walls in residents 10 and 17's rooms. *They both agreed that it was the maintenance and housekeeping staff's responsibility to keep those areas maintained, organized, and clean. 6. Interview on 12/18/2025 at 11:18 a.m. with director of nursing (DON) B revealed: *She stated it was the maintenance and housekeeping's responsibility to maintain and keep resident rooms and all facility areas organized and clean.*She expected that all resident rooms and utility rooms in the neighborhoods should be organized, well-maintained, and cleaned by the maintenance and housekeeping departments. Review of the provider's January 2025 Maintenance Service policy revealed:*Policy Interpretation and Implementation.-1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.-2. Functions of maintenance personnel include, but are not limited to:-.b. maintaining the building in good repair and free from hazards.- i. providing routinely scheduled maintenance service to all areas.- 5. Maintenance personnel shall follow established infection control precautions in the performance of their daily work assignments.-6. The maintenance director is responsible for maintaining the following records/reports:-.b. Work order requests.-7. Records shall be maintained in the maintenance director's office.-8. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and policy review, the provider failed to ensure that one of two medication carts was secured while administering medications.Findings Include:1. Observation on 12/17/25 at 11:35 a.m. of licensed practical nurse (LPN) K revealed:*LPN K had walked away from the [NAME] Way medication cart to talk to a resident in the dining area and had left the medication cart unsecured and unattended.*LPN K was not standing at the medication cart and returned to lock the cart at 11:41 a.m.*Several residents were seated in the dining area. 2. Interview on 12/18/25 at 11:00 a.m. with LPN K revealed:*She recalled walking away from the medication cart and not locking it on 12/17/25.*She reported she made a mistake, and she usually locked it when she walked away from it. The medication cart should have been locked each time she walked away from it to ensure it was secured from unauthorized access. 3. Interview on 12/18/25 at 12:00 p.m. with registered nurse (RN) neighborhood leader I revealed:*She witnessed LPN K when she walked away from the medication cart on 12/17/25.*She expected the medication cart to be locked anytime the employee administering medications walked away from it.*She confirmed that medications should be secured at all times. 4. Review of the provider's 1/2025 Security of a Medication Cart policy revealed:*The nurse/medication aide must secure the medication cart during the medication pass to prevent unauthorized entry.*Medication carts must be securely locked at all times when out of the nurse's/medication aide's view.

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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 observation, interview, and policy review, the provider failed to ensure a coffee maker/hot water dispenser in the Maple Valley neighborhood dining area was securely stored to protect the safety of vulnerable residents.Findings include: 1. Observation on 12/16/25 at 9:45 a.m. in the Maple Valley neighborhood (residential living area) revealed it 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, that is secured to minimize unsafe wandering). The unit's dining area was large and opened into a living room and a lounge area for the residents. Residents used the dining area not only for meals and snacks but also for structured social activities. Some of the six to eight residents who were present in the dining area during the observation walked independently or with the use of an assistive device, such as a walker. Other residents relied on the staff for their mobility. There was a countertop that extended the length of a wall on one side of the dining area. There was a set of tall cabinet doors on top of the countertop. The cabinet doors were positioned close enough to the edge of the countertop to be easily opened. There was an approximate one-inch gap when the two cabinet doors were closed. There was a broken, plastic safety device near the top of the cabinet doors to prevent the doors from opening. There was a cam lock (an L-shaped locking mechanism used to secure a cabinet door) towards the bottom of the right cabinet door. It was not engaged. Nothing prevented the cabinet doors from being opened. Behind the unsecured cabinet doors was a coffee maker that was equipped with a coffee warmer and a hot water dispenser. It was turned on and able to dispense hot liquids. 2. Observation on 12/17/25 at 3:45 p.m. in the Maple Valley dining area revealed that the above cabinet doors were closed and nothing prevented them from being opened. The temperature of the water dispensed from the hot water dispenser was tested by the surveyor, and it was 170 degrees. That was hot enough to have caused a third-degree burn if it had touched a resident's skin. 3. An interview conducted at the same time with certified nurse aide (CNA) X revealed that residents who had wandered towards the unsecured cabinet doors were redirected by staff before they were able to open the doors. CNA X was unsure how long the plastic security device on the cabinet door had been broken or if the maintenance department was aware that it needed to be fixed. She had not known where or if there was a key to secure the cam lock on the cabinet doors. She was not aware of any resident burn injuries related to a resident accessing hot beverages from behind those cabinet doors. She confirmed that the hot liquid temperature posed a burn risk if a resident accessed that machine. 4. Interview on 12/17/25 at 4:00 p.m. with administrator A and maintenance supervisor E regarding the above cabinets in the Maple Valley dining area revealed that they were not aware that the safety devices on the cabinet doors were either broken or unable to be used. It was expected that the staff would have promptly notified the maintenance department of this failure, so a temporary measure (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could have been implemented to ensure the residents' safety from a potential burn from the coffee maker/hot water dispenser until a permanent solution was in place. Review of the provider's January 2025 Hot Liquids Burn Prevention policy revealed 2. The cabinet containing hot liquids on Maple Valley is to remain inaccessible by use of childproof locks. Staff on Maple Valley also provide oversight to ensure that residents are not accessing hot liquids when they are unable to do so safely.