STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435096	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Sioux Falls	1901 South Holly Avenue Sioux Falls, SD 57105

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI) review, interview, record review, and policy review, the provider failed to ensure one of one licensed practical nurse (LPN) G followed facility policy, practiced within his scope of practice, and sought direction from a registered nurse (RN) or physician for one of one sampled resident (1) related to the family's concerns of the resident having a low hemoglobin blood level (protein in the red blood cells that carries oxygen). Findings include: 1. Review of the provider's 6/28/25 FRI submitted by the provider to the SD DOH regarding resident 1 revealed on 6/28/25 at around 7:40 p.m. LPN G documented a nursing progress note that stated Resident's daughter is concerned of possible gastrointestinal bleed (GI) due to stool being black and past like. I informed daughter its likely due to new medications but will update chart to bring light to the subject. There was no documentation to support that LPN G had assessed resident 1, called the resident's physician, or called the on-call leadership staff who was available 24 hours a day if needed. On 6/29/25 LPN G who was the night nurse the evening of 6/28/25 and reported to the oncoming day nurse, LPN D, that resident 1's daughter was concerned that she had a GI bleed. On 6/29/25 LPN D faxed resident 1's primary care physician and notified her of the daughter's concern of a GI bleed. Orders were received on 7/1/25 for a complete blood count (CBC), basic metabolic panel (BMP), and to check stool for blood. Additional orders were received for staff to monitor the resident's respiratory status and for lung sound changes. The physician was to be notified if the resident required an increase in oxygen. On 7/1/25 resident 1's daughter again expressed concerns of how the hemoglobin had dropped from when the resident was in the hospital. On 7/1/25 resident 1's primary physician ordered a stool specimen to be collected and sent for testing. The specimen was collected from the resident and sent to [NAME] Hospital lab. The specimen was not accepted due to being placed in the wrong specimen container. On 7/2/25 the correct specimen container to be placed in the stool to check for blood was ordered from [NAME] Hospital lab. On 7/3/25, the resident had been admitted to the hospital due to her having a critically low hemoglobin of 6.5 grams per deciliter (g/dl) (normal is 12.0-15.5 g/dl). There had been no time for the stool specimen to be collected prior to her hospitalization. 2. Review of resident 1's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. She had multiple co-morbidities that included: Osteomyelitis (infection of the bone) of the right ankle and foot. The resident had a diagnosis of long-term use of anticoagulants (thins the blood), type two diabetes mellitus with diabetic polyneuropathy (condition that affects many peripheral nerves, causing numbness, tingling, pain and weakness), insulin dependent, peripheral vascular disease (decreased blood flow to the legs), congestive heart failure, hypertension, atrial fibrillation irregular heartbeat). Continued review of resident 1's EMR at the time of admission on [DATE] revealed she was alert, orientated, and vital signs were stable. She was receiving antibiotics through a midline intravenous catheter placed in her left upper arm. Lab orders for a CBC and BMP were received from the hospital's infectious disease physician at the time of her admission to the facility on 6/26/25. The results from the 6/30/25 lab draw revealed her hemoglobin was 9 g/dl. That had been a 3.6 drop in the level since her last hemoglobin check during her hospitalization on 6/21/25. On 7/3/25 LPN D had received orders from the physician to recheck her hemoglobin again on 7/3/25. On 6/28/25 around 7:40 p.m. LPN G documented a nursing progress note that stated Resident daughter is concerned of possible gastrointestinal bleed (GI) due to stool being black and paste like. I informed daughter its likely due to new medications but will update chart to bring light to the subject. There was no documentation to support that LPN G had assessed resident 1, called the resident's physician, or called the on-call leadership staff who was available 24 hours a day if needed. Review of resident 1's care plan revealed her stay at the nursing home was to receive physical and occupational therapy and then return to her own home. 3. Interview on 10/28/25 at 1:36 p. m. with LPN D revealed when concerns are voiced by family members of a resident, the resident first needs to be assessed by the nurse. She indicated if further evaluation is needed after the initial assessment they are to reach out to E-Care (in the event of needing additional care that cannot be obtained at the facility), reach out to the on-call leadership staff and notify the physician. She stated that she assessed resident 1 on 6/29/25 and the resident's vitals were within normal limits and no other concerns were noted. She had indicated there was no documentation in the resident's EMR of black, tarry bowel movements from the time of admit on 6/26/25. She stated the resident was completely dependent on staff for toileting. She indicated that she notified resident 1's primary physician of the concerns