STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A137	A. BUILDING _____ B. WING _____	C 03/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BORMANN MANOR	501 NORTH 4TH STREET PARKSTON, SD 57366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An extended complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 3/31/25. Areas surveyed included accidents and hazards, quality of nursing services, medication administration, food services, and environment. Avera Bormann Manor was found to have past non-compliance at F689. On 3/31/25 at 9:00 a.m. Immediate Jeopardy (IJ) was identified for resident safety related to a facility-reported incident that occurred on 3/25/25 when a resident (1) fell from a bath chair, received serious injuries, and later died. The investigation revealed staff education and competencies initiated on 3/25/25 removed the immediacy. On 3/31/25 at 5:00 p.m. administrator A was informed of the IJ and was given the IJ template. Substantial compliance was confirmed on 3/31/25 at 4:00 p.m. after review of the providers corrective actions revealed the provider had followed its quality assurance process, the provider's whirlpool bath policy was updated to ensure safety measures would be implemented, staff education was provided, and competencies were completed regarding safety precautions, including the use of the bath chair lift safety belt, safety checks, and interventions for resident refusals to wear the safety belt. Observations and staff interviews revealed staff understood the education provided and the proper use of safety precautions. All resident care plans were updated as applicable to address resident refusals to use	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	04/14/2025

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.

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F 000	Continued From page 1 the safety belt. Audits were implemented and staff monitoring will continue for compliance with safety precautions. That data will be reported at the monthly QAPI meetings by the DON or designee. The provider was found to have past non-compliance at F689 related to the staff's failure to use the safety belt for the mechanical bath chair lift for a resident that caused that resident to fall and sustain injuries that required hospitalization and subsequent death. The current census was 46.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI) review, record review, observation, interview, and policy review, the provider failed to ensure the safety of one of one sampled resident (1) who fell from a mechanical bath chair lift, suffered injuries that required emergency room treatment, hospitalization, and subsequently died when one of one certified nursing assistant (CNA) (C) failed to ensure a safety belt was used. This citation is considered past non-compliance based on review	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 of the corrective actions the provider implemented immediately following the incident. On 3/31/25 at 9:00 a.m. Immediate Jeopardy (IJ) was identified for resident safety related to a facility-reported incident that occurred on 3/25/25 when a resident (1) fell from a bath chair, received serious injuries, and later died. The investigation revealed staff education and competencies initiated on 3/25/25 removed the immediacy. On 3/31/25 at 5:00 p.m. administrator A was informed of the IJ and was given the IJ template. The current census was 46. Substantial compliance was confirmed on 3/31/25 at 4:00 p.m. after review of the providers corrective actions revealed the provider had followed its quality assurance process, the provider's whirlpool bath policy was updated to ensure safety measures would be implemented, staff education was provided, and competencies were completed regarding safety precautions, including the use of the bath chair lift safety belt, safety checks, and interventions for resident refusals to wear the safety belt. Observations and staff interviews revealed staff understood the education provided and the proper use of safety precautions. All resident care plans were updated as applicable to address resident refusals to use the safety belt. Audits were implemented and staff monitoring will continue for compliance with safety precautions. That data will be reported at the monthly QAPI meetings by the DON or designee. Findings include.	F 689		

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F 689	Continued From page 3 1. Review of the provider's 3/25/25 SD DOH FRI regarding resident 1 in the tub room revealed: *On 3/25/25 at 6:36 a.m. resident 1 had taken a whirlpool bath and was sitting on a mechanical bath chair lift approximately 25 to 30 inches high. *She had resisted wearing a safety belt. *CNA C had turned to grab the resident's clothing and heard a noise. *Resident 1 had fallen onto the floor. -CNA C called for assistance of other staff. -A registered nurse (RN) arrived and noted the resident had a left forehead hematoma with a laceration. -Staff used a total body mechanical lift (a mechanical lift and sling used to lift a person's full body) to assist resident 1 into a wheelchair and she was transferred to the emergency room for evaluation. *Resident 1 had a Brief Interview for Mental Status (BIMS) assessment score of 0, which indicated she had severe cognitive impairment. *Resident 1 was hospitalized on 3/25/25 with non-displaced fractures involving ribs 2, 4, 5, 6, 7, and 8, and a confirmed apical pneumothorax (air accumulation in the space between the lungs and the chest wall). *Resident 1 was readmitted to the facility on 3/26/25 on hospice services. *Resident 1 passed away on 3/27/25. 2. Interview on 3/31/25 at 10:49 a.m. with administrator A revealed: *All CNAs who were scheduled to provide resident care in the tub room were retrained and provided competencies regarding the mechanical bath chair lift and safety strap use that were to be completed before bathing residents. *All other CNAs were retrained and provided competencies in case they worked in the tub	F 689		

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F 689	Continued From page 4 room. *The director of nursing (DON) B or designee would be completing audits of the bathing process of the mechanical bath chair lift and safety strap use following the manufacturers guidelines five times a week for 30 days and then three times a week for 2 months. *Their next QAPI (Quality Assurance and Performance Improvement) meeting was scheduled for 3/31/25 and they planned to review the new policies and competencies to ensure they were effective in preventing the reoccurrence of similar incidents. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 3/31/25 after a record review revealed: *The provider had followed its quality assurance process and education was provided to staff who would be providing bathing to residents. -The staff had been educated regarding safety precautions including using a safety belt on all residents, competencies were conducted, and audits had been completed on 19 residents from 3/26/25 through 3/28/25 with the expectation to complete auditing five times per week for 30 days and then three times per week for 2 months by DON B or the designee. *Audit data would be reported to QAPI monthly by the DON. *The provider's Whirlpool Bath policy was updated to ensure safety measures to be implemented. *Observations and staff interviews revealed the staff understood how to use the safety belt and perform other safety checks within the tub room before bathing residents, and what to do if a cognitively impaired resident refused to use the safety belt.	F 689		

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F 689	Continued From page 5 *All residents care plans were updated as necessary based on refusal of using a safety belt and alternative bathing interventions. Based on the above information, non-compliance at F689 occurred on 3/25/25, and based on the provider's implemented corrective actions for the deficient practice confirmed on 3/31/25, the non-compliance is considered past non-compliance.	F 689		