STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435061	A. BUILDING B. WING	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN , MITCHELL, South Dakota, 57301

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/21/26 through 4/23/26 and on 4/27/26. Avera Brady Health and Rehab was found not in compliance with the following requirements: F684 and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 4/21/26 through 4/23/26 and on 4/27/26. The area surveyed was quality of care related to a residents call system cord malfunctioning, which resulted in the resident experiencing an additional 30-minute delay in receiving staff assistance for activities of daily living (ADLS). Avera Brady Health and Rehab was found not in compliance with the following requirement: F684.	F0000		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, interview, document review, record review, and policy review, the provider failed to protect the resident's right to quality of care according to the resident's assessment and needs for one of one sampled resident (41) whose call system cord was not working and was on a commode (portable toilet) for one hour and fifteen	F0684	1) Maintenance staff did a full function test of residents' call system on 4/2/26 upon installation of the new Arial Call Light Server. On 4/23/26, Maintenance verified all call system cords and boxes were fully functional. 2) Beginning on 4/23/26, all staff are being educated by the Director of Nursing/Designee to the the policy that we inform maintenance of any call light malfunctions, including malfunctions in the call system cord. Any staff members not present for the education will be educated prior to their next shift worked. Staff willl sign that education was received. Maintenance will perform monthly preventative maintenance to ensure the call system cords are working effectively. 3) Maintenance Supervisor/Designee will audit five residents' call system cords one time per week to ensure that call system cords are properly functioning. This audit will be done weekly for three months. Data collected will be brought to the QAPI committee monthly by the Maintenance Supervisor for three months. Recommendations for further studies will be made by the QAPI Committee.	5/6/2026

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 reverse for further 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
Kimberly Boomgaarden	CEO/Administrator	5/20/2026

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	435061	A. BUILDING B. WING	04/27/2026

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F0684 SS = D	Continued from page 1 minutes, which was 30 minutes longer than the resident's preference, by one of one certified nursing assistant (CNA) N who did not return to resident 41's room to check on her. That failure resulted in emotional distress for the resident, who was observed by administrator (A) as being distressed, upset, and having tears in her eyes when discussing the incident. The provider failed to assess other residents' call system cords to ensure they were functioning to enable them to call for staff assistance, putting all residents who needed staff assistance with their care at risk of serious adverse outcomes such as pressure ulcers, falling, emotional distress, injury, and/or serious harm, specifically if the resident attempted to call for help with no response. Findings include: 1. Review of the SD DOH FRI revealed that on 3/5/26 at 5:15 p.m., resident 41 was heard yelling from her room by a registered nurse (RN) who was working nearby. The RN entered the room and found resident 41 sitting on the commode. The resident was "upset" and stated that she had been waiting for someone to answer her light [call light]. Resident 41 stated she had tried to call for help to get off the toilet at 4:45 p.m. The RN tried to activate the call light, and it would not turn on. The RN determined the call light was not activated when resident 41 had pushed the call button attached to the call system cord. She unplugged the cord from the call system box, and after plugging it back in, the call system cord began to work. Maintenance staff were notified and came at 6:30 p.m. and changed the call system cord that did not activate properly. An additional call system and call system cord were placed in resident 41's room that would be closer to the resident when she was using the commode. The provider's final report for the SD DOH FRI indicated CNA N was educated on the importance of placing an orange magnet on the outside of a resident's room door to indicate that a resident was on the toilet to ensure the resident was checked on by staff for the resident's safety, especially if the resident's room door was closed. All staff were re-educated on the use of orange magnets. Resident 41 had no signs of skin damage related to the incident. Resident 41 stated she would like to make sure her cell phone was within her reach when using the commode, so she would be able to call in the future when she needed assistance. The provider determined the resident was on the commode for approximately 30 minutes longer than she had	F0684		

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F0684 SS = D	Continued from page 2 wanted to be. 2. Observation and interview on 4/21/26 at 5:20 p.m. with resident 41 in her room revealed that there was a bariatric-size (for plus-size residents) commode next to the bathroom door. Resident 41 stated she "always" wore an incontinence (involuntary urine or bowel leakage) brief as she was "having problems" with her bowels. She indicated that she had "really big and really messy BM's (bowel movements)" at least three times in the last two days. Resident 41 indicated she used the commode rather than the toilet and would sit on the commode "for a while." She preferred to have her door left open "only a crack", she indicated she was a very private person and liked to make her own decisions. 3. An interview was attempted on 4/23/26 at 12:46 p.m. with resident 41. She declined to speak to the surveyor as she was "watching television" and "I don't want to be interrupted." 4. Interview on 4/22/26 at 1:51 p.m. with maintenance supervisor D regarding the monitoring of the residents' call systems revealed that all call systems were checked yearly to ensure they were working. 5. Interview, document review, and policy review on 4/22/26 at 3:15 p.m. with administrator A regarding the process for ensuring residents were monitored while being assisted with their toileting needs and the residents' call system revealed that the staff was to leave the call system cord within the residents' reach when the resident was assisted to the toilet or commode in their room. After the staff exited the residents' room, they were to place an orange magnet on the outside of the residents' doorframe to indicate that the resident was on the toilet or commode. Administrator A indicated that the 3/5/26 incident regarding resident 41 being left on the commode for an extended period of time, was investigated and that the root cause analysis of this incident was related to the orange magnet not being placed on the resident's door frame. Administrator A stated that on 3/6/26, she had provided education to staff members regarding the "Orange Magnet Process Reminder". That documented education indicated "This is a reminder that it is an important safety measure to remember to use orange magnets outside a resident's door when they are on the toilet or commode. This should	F0684		

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F0684 SS = D	Continued from page 3 be done on ALL shifts to let the nurse and your partner [co-worker] know that someone is on the toilet if they are covering for you or you are ending your shift." Administrator A stated she had visited with resident 41 about the incident on 3/5/26 and stated that resident 41 was "distressed, she was upset, and had tears" as she had sat on the commode for 30 minutes longer than she had wanted to be there, as her call system cord had malfunctioned and did not alert staff members she needed assistance. Administrator A reviewed the provider's 2/6/25 Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy that included, "Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress." Administrator A acknowledged that, based on this policy, the 3/5/26 incident of resident 41's call system cord not functioning resulted in the neglect of resident 41. Administrator A stated, "We just changed out the call light computer recently, so we did a review of all call lights." She then stated, "We do skin monitoring, and she [resident 41] had no [skin] issues [after the incident]." 6. Interview conducted on 4/23/26 at 8:00 a.m. with maintenance supervisor D regarding the residents' call system boxes revealed that, in late 2023 or sometime in 2024 (exact date uncertain), the provider began replacing the call system boxes located in resident rooms. This replacement process included ongoing updates, with several call system cords being replaced each year as part of the project. Maintenance supervisor D indicated that staff members could submit work orders for any issues related to the call light system, including instances where a device was not functioning properly or when a warning, such as a low battery alert, was triggered. Maintenance supervisor D indicated that the call light monitoring system was reviewed each morning. The system generated alerts that were displayed on workstation computers and on monitors located at the end of each hallway, which alerted the staff to issues such as missing devices or low batteries of the call system. If an alert was not promptly	F0684		

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F0684 SS = D	Continued from page 4 addressed, the system would continue to alarm every five minutes until the issue was resolved. The call system was designed to support up to three call system devices in each resident's room. Maintenance supervisor D reported that a new server for the call system was installed on 4/2/26 after an attempted update to Windows 12 rendered the system incompatible with the existing call light software. Following installation of the new server, all call light components, including each resident's call system cord to ensure they were functioning. Maintenance supervisor D stated that the call system was audited manually, once each year, usually in July, to ensure the entire system was working, including each resident's call system cord. The annual call light system audit was not completed for 2026. Regarding resident 41, maintenance supervisor D reported that on 3/5/26, he was notified by a staff member of an issue with resident 41's call system. Upon his inspection, it was determined that the zip ties securing the call system cord to the call system box had been cut. As a result, the resident pulled the cord with sufficient force to bend the internal components of the call light box, resulting in the call system cord not being able to activate the call system. Maintenance supervisor D stated, "I relocated the call system box to the north wall between the bathroom wall and the sink, installed a new call system box and call system cord, and adjusted the placement so the cord could reach the resident's chair without requiring excessive tension when the resident was on the commode." He further indicated that he provided education to the staff members on duty at the time regarding the incident. He did not document this education. 7. Interview conducted on 4/23/26 at 10:10 a.m. with administrator A regarding the call light system revealed that the investigation into resident 41's call system not functioning on 3/5/26 determined the issue was not with the call light system itself, but with CNA not using the orange magnet to indicate resident 41 was using the commode. The orange magnet serves as a secondary check when the call light was not functioning. Administrator A indicated there was no call system delay for resident 41's room on 3/5/26 recorded by the monitoring system, as the call system cord was not operating. She further explained that the call	F0684		

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F0684 SS = D	Continued from page 5 monitoring system was capable of detecting when a call system cord is missing, but it could not detect whether the call system cord was functioning or not. Administrator A acknowledged that a non-functioning call system cord could potentially result in an accident or injury to a resident. She stated, "That is why maintenance was contacted immediately upon discovery of the issue. If the cord had deactivated the box, the monitoring system would have identified it." Administrator A explained that the call system monitoring operates on an external network device and is electronically monitored through a continuous system "sweep." This call light monitoring system identifies issues such as low battery levels or missing components, including call system cords that may be missing. The facility's investigation regarding resident 41's incident on 3/5/26, determined that a secondary issue with Resident 41's call light was the call system cord not working. Administrator A reported that when the nurse tested the cord several minutes after the call system cord malfunctioned, it successfully activated the call system. 8. Interview and review of the provider's call system monitoring checklist, which maintenance personnel were to document any repairs to a resident's call system on 4/23/26 at 8:54 a.m. with maintenance supervisor D revealed that the checklist was not consistently utilized by all maintenance personnel, although maintenance supervisor D indicated he made efforts to keep it current. There was no documented evidence on the checklist regarding resident 41's 3/5/26 incident involving the call system cord. Maintenance supervisor D stated that some information related to the incident "might be on the old [computer] server," but he was unable to access those records. 9. Review of resident 41's electronic medical record (EMR) revealed she was admitted to the facility on 2/8/23. Her 4/3/26 Brief Interview of Mental Status (BIMS) assessment score was a 13, which indicated her cognition was intact. Resident 41's diagnoses included morbid obesity (excessive weight that significantly impacts health and well-being), depression, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), chronic pain, constipation, fibromyalgia, and overactive bladder.	F0684		

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F0684 SS = D	Continued from page 6 Resident 41's 4/22/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she required the assistance of two staff members and a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) for her toileting needs. She used a bedside commode and liked to watch television when using it. She had bowel and bladder incontinence and wore an incontinence brief during the day and night. Resident 41 wanted to be toileted at 4 a.m. and would use her call light the "rest of the time." She was at risk for falling, and her door was to be left open "unless sleeping then it may be closed but I need to be checked on frequently." Staff members were to continue to "educate on fall risk reinforce use of call light [system]." She had a cell phone and was able to use it independently. 10. Review of the provider's 4/8/26 Quality Assurance Performance Improvement (QAPI) meeting revealed "Quality Measures" included "call lights." The minutes did not include how the call lights were included in the Quality Measures. Under the title of "State Notifications" there was an indication that resident 41 was "left on commode [the staff] moved placement of [the] call light; updated care plan; question why she is sitting a long [time]... BM or bladder?" The column of "Action" included "Nursing: Assess with [resident 41's name redacted] why she is sitting for so long." 11. Review of the manufacturer's Call Station Installation Guide revealed the "Ariel ES Call Station is a wireless, battery-operated, fixed-location resident call device. The alarm may be activated by a large, easy to press push-button, a pull cord, or an optional remote pushbutton." The "ES call Station is also equipped with a dual-purpose Call Cancel/Check-In button. In concert with Arial software, residents can check in using the ES Call Station." The general operation of the call station was completely wireless and easy to use. The call station sends a supervision signal to the Arial server approximately every 5 minutes. The resident initiates an alarm by pressing the large blue call button, by pulling the red cord, or by pressing an optional push-button cord. The red LED would turn on and remain lit until the alarm was cancelled. A "Warning" listed in the manufacturer's instructions included "If using optional push-button cords, inspect all connectors following every alarm.	F0684		

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F0684 SS = D	Continued from page 7 If good electrical connections are not being made, subsequent use of the push-button cord may not issue an alarm, which could lead to the injury or death of a resident." 12. Review of the provider's August 2024 Call Light(s) policy revealed that a functioning call "light" system was required. Call system "scores" were calculated monthly. The goal was to answer call system lights within 10 minutes 87% of the time. If the call light was defective, the staff were to report it immediately to maintenance.	F0684		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, employee education review, and policy review, the provider failed to ensure standard food-safety practices were followed for one of one observed cook I who did no perform hand hygiene (washing or sanitizing hands) after she dropped and picked up a butter container lid from the floor, and coughed into her right hand and drank from her personal beverage cup while preparing and serving resident meals during the lunch meal service.	F0812	Staff will perform hand hygiene as needed to ensure safe food handling. All staff responsible for food service, including cook I were educated to perform appropriate hand hygiene during meal service per the policy by the food service manager on 5/5/2026. Staff will sign that this training was recieved. A hand hygeine audit will be completed by the food service manager for 1 meal per week for 3 months.The food service manager will bring data collected from the hand hygiene audits to QAPI committee monthly for three months. Recommendations for further studies will be made by the QAPI committee.	5/13/2026

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F0812 SS = D	Continued from page 8 Findings include: 1. Observation on 4/21/26 from 12:15 p.m. through 1:00 p.m., in the Vasek kitchenette and dining room, revealed that cook I dropped the lid to the butter container onto the floor. She then picked the lid up and placed it on the counter next to an open bag of bagels. Cook, I did not perform hand hygiene after handling the lid that had fallen onto the floor. Cook I prepared a plate of food for a resident. While holding the plate in her left hand, cook I turned her head to the right and coughed into her right hand. She then continued preparing additional plates of food for residents without performing hand hygiene. There was one bottle of hand sanitizer on the counter next to the steam table line and one hand sanitizer dispenser on the North wall of the dining room. Cook I had her personal cup sitting on top of the food transport cart (a cart used to transfer food from the main kitchen to the residents' room). The cart was located within the Vasek kitchenette next to the serving line. She took a drink from the cup placed it back on top of the food transport cart and without performing hand hygiene and prepared additional plates of food for the residents 2. Interview on 4/21/26 at 1:36 p.m. with assistant dietary manager (ADM) F revealed that the personal cup that belonged to cook I, which was on top of the food transport cart, was an appropriate space for cook I to place it. 3. Interview on 4/22/26 at 1:15 p.m. with cook I revealed that on 4/21/26 at 12:30 p.m., she had coughed into her right hand while holding a plate of food in her left hand she was plating for the residents during the lunch meal. Cook I stated she should have set the plate down and washed her hands after she coughed into her right hand. She indicated she should have started over with a clean plate to serve the resident's food on. 4. Interview on 4/22/26 at 1:20 p.m. with ADM F revealed that cook I should have set the plate of food down that she had in her left hand and washed	F0812		

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F0812 SS = D	Continued from page 9 her hands after she had coughed into her right hand. ADM F indicated they had designated spaces for the staff to keep their personal cups with lids. She stated areas where food was being prepped for the residents were not considered safe spaces for the staff beverages. 5. Interview on 4/22/26 at 1:40 p.m. with dietary manager (DM) E, revealed she expected that cook I wash her hands after she coughed into her right hand before she started serving the resident's food. DM E indicated that the top of the food transport cart was not a designated space for the staff to keep their personal cups on. She expected the staff to follow the provider's hand hygiene policy. 6. Review of Cook I's Continuing Education Transcript Report revealed she had received annual education on Infection Control and Prevention on 3/21/26 and Food Safety and Sanitation education on 8/2/25. 7. Review of the provider's revised May 2023 Avera Handwashing policy revealed the purpose was to "prevent the spread of disease or other contamination of food or food utensils. The staff were to wash their hands after handling soiled dishes and utensils, sneezing and using a tissue." 8. Review of the provider's revised April 2026 Avera LTC-Infection Prevention Program and Authority policy revealed: "a. Long Term Care (LTC) employees are given information and education in the infection prevention and control. Education will be completed as needed at the direction of the QAPI Committee." "1. Mandatory education for infection prevention and control will be held on a routine basis and may include such information as bloodborne pathogens, Tuberculosis (TB) Standard Precautions, hand hygiene, disinfection, Healthcare-Associated Infection (HAI) prevention, and proper Personal Protective Equipment (PPE) use. Documentation of annual education is retained by the Department Supervisor and/or Education Department."	F0812		

South Dakota Department of Health

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	10652	A. BUILDING: _____ B. WING _____	04/27/2026

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/21/26 through 4/23/26 and 4/27/26. Avera Brady Health and Rehab was found not in compliance with the following requirements: S206 and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel	S 206	Employee L & M's required education is complete as of 3/14/26 and 3/6/26 respectively. All new hires since 1/1/2026 have completed required orientation. Leaders are having new hires complete education before beginning any hands on training. New hires will complete their required orientation within 30 days of their hire date. Administrator will audit new employees weekly-upon hire and throughout the initial 30 days to ensure training is completed. Data will be collected and brought to QAPI committee by Administrator monthly for three months. Recommendations for further studies will be by by the QAPI Committee.	5/13/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO/Administrator | (X6) DATE: 5/21/2026 5/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10652	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN MITCHELL, SD 57301

(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) COMPLETE DATE
S 206	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure that two of five reviewed employees (L and M) completed the required orientation training within 30 days of being hired. Findings include: 1. Review of certified nursing assistant (CNA) L's personnel file revealed she was hired at the facility on 1/26/26. She did not complete the required orientation training on dining assistance, nutritional risks, residents' hydration needs, and advance directives within 30 days of being hired. 2. Review of activity assistant M's employee file revealed she was hired at the facility on 9/29/25. She did not complete the required orientation training on dining assistance, nutritional risks, residents' hydration needs, and advance directives within 30 days of being hired. 3. Interview on 4/27/26 at 5:51 p.m. with administrator A and director of nursing (DON) B regarding staff education and training revealed that the corporate office assigned the required training through an online platform and that they could access training transcripts to monitor employee progress. They acknowledged that the orientation training for these employees was not completed within the required time frames. 4. Review of the provider's 7/2/24 Education-Development policy revealed: "Mandatory Education Requirements ... are required for all employees. It is expected that all	S 206		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10652	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN MITCHELL, SD 57301

(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) COMPLETE DATE
S 206	Continued From page 2 employees complete new hire education, annual mandatory education, and ongoing designated mandatory education as a mechanism to ensure competency." "Failure to meet mandatory education requirements as designated may result in corrective action ...[and] may also result in immediate suspension without pay until the requirement is completed. Employees will be given a specific time frame to complete the mandatory education."	S 206		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure that two of five reviewed dietary employees (J and K) completed the required dietary orientation training within 30 days of being hired.	S 301	Employee J & K's required dietary education was complete on 3/23/26 & 1/19/26 respectively. Food service manager will have all dietary employees complete new hire education before any hands on training. All new hires since 1/1/2026 have completed required dietary orientation. New hires will complete their required dietary orientation within 30 days of their hire date. Food Service Manager will audit new employees upon hire and throughout the initial 30 days to ensure training is completed. Data will be collected and brought to QAPI committee by Food Service Manager monthly for three months. Recommendations for further studies will be by by the QAPI Committee.	5/13/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10652	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN MITCHELL, SD 57301

(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) COMPLETE DATE
S 301	Continued From page 3 Findings include: 1. Review of food service worker (FSW) J's personnel file revealed he was hired at the facility on 12/15/25. He did not complete the required dietary orientation training on food handling and preparation within 30 days of being hired. 2. Review of FSW K's personnel file revealed she was hired on 2/2/26. She did not complete the required dietary orientation training on hand washing, nutrition, and hydration within 30 days of being hired. 3. Interview on 4/27/26 at 5:51 p.m. with administrator A and director of nursing (DON) B regarding staff education and training revealed that the corporate office assigned the required training through an online platform and that they could access training transcripts to monitor employee progress. They acknowledged that the dietary orientation training for these employees was not completed within the required time frames. 4. Review of the provider's 7/2/24 Education-Development policy revealed: "Mandatory Education Requirements ... are required for all employees. It is expected that all employees complete new hire education, annual mandatory education, and ongoing designated mandatory education as a mechanism to ensure competency." "Failure to meet mandatory education requirements as designated may result in corrective action ...[and] may also result in immediate suspension without pay until the requirement is completed. Employees will be given a specific time frame to complete the mandatory education."	S 301		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10652	A. BUILDING: _____ B. WING _____	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN MITCHELL, SD 57301

(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) COMPLETE DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN , MITCHELL, South Dakota, 57301

(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
E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 4/21/26. Avera Brady Health and Rehab was found in compliance.	E0000		

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 reverse for further 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
[signature]	CEO/Administrator	5/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435061	A. BUILDING **01 - MAIN BUILD...** B. WING	**04/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	**500 S OHLMAN , MITCHELL, South Dakota, 57301**

(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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 4/21/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Brady Health and Rehab was found in compliance.	K0000		

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 reverse for further 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
[signature]	CEO/Administrator	5/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	500 S OHLMAN , MITCHELL, South Dakota, 57301

(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
K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 4/21/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Brady Health and Rehab was found in compliance.	K0000		

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 reverse for further 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
Kimberly Boomer	CEO/Administrator	5/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061	(X2) MULTIPLE CONSTRUCTION A. BUILDING **03 - NORTH ADDI...** B. WING	(X3) DATE SURVEY COMPLETED **04/21/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BRADY HEALTH AND REHAB	**500 S OHLMAN , MITCHELL, South Dakota, 57301**

(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
K0000 Bldg. 03	INITIAL COMMENTS A recertification survey was conducted on 4/21/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Brady Health and Rehab was found in compliance.	K0000		

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 reverse for further 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
[signature]	CEO/Administrator	5/13/2026