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 06/26/2025

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 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/25/25 through 6/26/25. The area surveyed was accident hazards when a resident fell out of a lift chair. Avera Bormann Manor was found to have past non-compliance at F689.	F 000		
F 689 SS=G	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 incident (FRI), record review, interview, and policy review, the provider failed to assess for safe usage of a lift chair for one of one sampled resident (1) who had an unwitnessed fall and required hospitalization for injuries acquired from the fall and pain management. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident. Findings include: 1. Review of provider's 5/27/25 SD DOH FRI for resident 1 revealed: *On 5/24/25 the resident was found on the floor in front of her lift chair laying on her right side.	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/8/2025

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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*Her lift chair was raised all the way up in the air.
*She was unsure how she fell and ended up on the floor.
*She had a large hematoma (collection of blood outside a blood vessel) to the left side of her forehead.
*She had a skin tear and bruise on the top of her right hand.
*She had adequate range of motion (ROM) to all four extremities.
*Her neurological assessment was within normal limits (WNL).
*She had good neck ROM from side to side and when looking down.
*She had complained of discomfort when looking up towards the ceiling.
*Ice was applied to her forehead after being assisted with a total lift from the floor into her wheelchair.
*Her family was notified of fall.
*Her primary care provider (PCP) was notified of the fall and he advised the staff to monitor and notify him of any change in the resident's condition.
*On 5/27/25 she was having complaints of neck pain and was sent to the local clinic for evaluation.
*A computed tomography (CT) scan was completed and revealed:
-An acute nondisplaced fracture of the C2 (second cervical vertebra).
-A suspected acute nondisplaced type 1 dens fracture (a break at the tip of the second cervical vertebra).
*She was admitted to the local hospital on 5/27/25 for observation, and then admitted as an inpatient on 5/28/25 for pain control and a neurosurgery consult.
*She returned to the facility on 5/29/25 at 2:57

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F 689	Continued From page 2	F 689		

p.m. and was admitted to hospice on 5/30/35.
*No lift chair safety assessment had been documented for the resident prior to the fall on 5/24/25.

2. Review of resident 1's electronic medical record (EMR) revealed:
*She admitted to the facility on 9/10/24.
*She was identified as having a high fall risk on her 3/6/25 and 5/24/25 fall risk assessments.
*Her Brief Interview for Mental Status (BIMS) assessment score on 5/22/25 was three indicating she had severely impaired cognition.
*She had the above fall with injury from her lift chair on 5/24/25.
-She was admitted to the hospital on 5/27/25 and returned to the facility on 5/29/25.
*She was admitted to hospice services in the facility on 5/30/25.
*She had a lift chair safety assessment completed on 5/30/25, after her 5/24/25 fall.
-That assessment found she needed total assistance from others to operate her lift chair.
*Her lift chair was unplugged from the wall, and her family was notified.
*She passed away on 6/4/25.

3. Interview on 6/26/25 at 9:14 a.m. with registered nurse (RN)/Minimum Data Set (MDS) coordinator C revealed:
*She had worked for the facility for almost six years.
*Resident 1 did not have a lift chair safety assessment completed before her 5/24/25 fall incident.
*Resident 1 had a lift chair safety assessment completed after her return from the hospital on 5/30/25.
*Nurses were responsible for resident

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assessments at the time of a resident's admission.
*She completed the quarterly, significant change, comprehensive and annual assessments for residents with their MDS assessments.
*Nurses should know resident assessments were due as they would be on the worklist in the resident's EMR to be completed at certain times.
*She received education following the incident on 5/24/25 for resident 1 related to completing lift chair safety assessments and when they were due.
*All residents who used a lift chair had lift chair safety assessments completed after resident 1's incident on 5/24/25.

Interview on 6/26/25 at 9:26 a.m. with director of nursing (DON) B revealed:
*She started her position on 5/19/25.
*Floor nurses completed resident assessments which triggered on worklists in the EMR to be completed at certain times.
*RN/MDS coordinator C would complete resident assessments when their MDS assessment was due.
*She expected assessments to be completed when they were due.
*She agreed that lift chair safety assessments had not been completed for any residents prior to the incident on 5/24/25 with resident 1.
*She and RN D had completed all lift chair safety assessments for residents following the 5/24/25 incident.
*She and RN D had also updated all resident care plans following that 5/24/25 incident.

Interview on 6/26/25 at 9:52 a.m. with administrator A revealed:
*She expected resident assessments to be

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completed when the resident assessment instrument (RAI)/MDS schedule stated they needed to be completed and upon the resident's admission to the facility.
*She expected the provider's policies to be followed when they were implemented and development of a plan during the quality assurance and performance improvement (QAPI) process.
*She agreed lift chair safety assessments had not been completed for residents prior to resident 1's 5/24/25 fall from her lift chair.

4. Review of the provider's October 2024 Lift Chair Safety Assessment Policy revealed:
*"A. Before a lift chair is used by a resident, a member of the intradisciplinary team will complete a lift chair safety assessment."

The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 6/26/25 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding lift chair safety assessments and care plan updating. Interviews with nursing staff revealed they understood the education provided regarding the topics. Observation of lift chairs in residents' rooms were conducted. Audits were completed for newly admitted resident's, assessments were being completed, and residents' care plans were updated.

Based on the above information, non-compliance at F689 occurred on 5/24/25, and based on the provider's implemented corrective action for the deficient practice confirmed on 6/26/25, the non-compliance is considered past non-compliance.

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