STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA OAHE MANOR	700 E GARFIELD , GETTYSBURG, South Dakota, 57442

(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 7/29/25 through 7/31/25. Avera Oahe Manor was found not in compliance with the following requirements: F657, F658, F727, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/29/25 through 7/31/25. Areas surveyed included quality of care related to a resident who spilled hot coffee and sustained a burn, and potentially missing fentanyl patches. Avera Oahe Manor was found not in compliance with the following requirement: F689.	F0000		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F0657	Resident 5's care plan was updated on August 21, 2025 to reflect appropriate undergarments and incontinence products, ambulation and fall risk with standby assist or assist of 1, wheelchair use as needed. Resident 38's care plan was updated on August 30, 2025 to reflect discontinue of Foley catheter on June 27, 2025. All residents are potentially at risk. Care Plan policy reviewed with no identified updates needed on August 22, 2025. DON or designee will educate the care plan team (DON, Director of Resident Care, Activity Coordinator, LPN Nurse Coordinator, Certified Dietary Manager, and MDS Coordinator) to ensure all care plans are updated and more person-centered and individualized by August 28, 2025. Administrator will educate nursing by August 28, 2025, to notify the care plan team about resident care need changes so the care plan team can update the care plan. Care plans will be reviewed and updated as needed per MDS schedule and with individual care need changes. Audits to ensure care plans are more person centered and individualized will be conducted on 3 care plans weekly for three months then monthly for 4 months by DON/LPN Coordinator or designee. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by DON or designee and reviewed for one year or until deemed no longer necessary.	August 28, 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 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
Rena Robbennolt CNP	Administrator	8/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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F0657 SS = E	Continued from page 1 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review the provider failed to ensure, the care plans were updated for one of one sampled resident (5) to reflect her current care needs, and one of one sampled resident (38) who no longer had a urinary catheter. Findings include: 1. Observation on 7/29/25 at 2:50 p.m. of resident 5 revealed: *She was sitting in a recliner with her feet elevated in the common area. *She began sitting forward and attempted to scoot forward in the recliner. *Certified nursing assistant (CNA) J asked resident 5 to wait a moment until she got resident 5's wheelchair. *CNA J then assisted resident 5 in transferring to her wheelchair. Observation and interview on 7/30/25 at 11:28 a.m. with registered nurse (RN) G revealed: *She pushed resident 5 in her wheelchair into her room. *RN G stated resident 5 was able to walk, but she was unsteady and had a high risk for falling. *RN G assisted resident 5 to a standing position, held her hands, and provided cues for resident 5 to walk into the bathroom. *RN G stated resident 5 would attempt to stand and walk independently at times, but staff would watch her closely and walk with her. *RN G stated resident 5 was usually continent of urine but wore a liner in her underwear at night.	F0657		

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F0657 SS = E	Continued from page 2 *Resident 5 was not wearing an incontinence product at that time. Review of resident 5's 7/30/25 care plan revealed: *The ADLs (activities of daily living) focus area indicated, -She was incontinent two or more times a week and wore a large pull-up. -She transferred and walked in her room independently. -She used the toilet independently. *The intervention area of bowel and bladder indicated she, -Used a panty liner for bladder leakage. Review of the 7/31/25 care sheet revealed: *Resident 5 used a wheelchair. *Staff were to walk with her in the hallway when she was restless. *She did not require any incontinence products. Interview on 7/31/25 at 10:04 a.m. with CNA M revealed: *Each staff member received a resident care sheet at the beginning of their shift that included, general care needs information for each resident. *In addition to the care sheets, she referenced the residents' care plans in the computer system to determine the care assistance she needed to provide to each resident. *Resident 5 spent most of the time in her wheelchair. *She would get up and attempt to walk independently at times, but staff would monitor her closely, and would walk with her for her safety when she stood up. 2. Observation and interview on 7/29/25 at 2:52 p.m. with resident 38 revealed: *He did not have a urinary catheter. Record review of resident 38's electronic medical record revealed:	F0657		

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F0657 SS = E	Continued from page 3 *His medical orders from 6/1/25 through 7/30/25 indicated he did not have a urinary catheter order and it was discontinued on 6/12/25. *His care plan indicated he had a urinary catheter from an outside facility related to urinary incontinence. Interview on 7/30/25 at 8:53 a.m. with CNA S regarding resident 38 revealed he did not have a urinary catheter as noted on his care plan dated 6/20/25. 3. Interview on 7/31/25 at 10:04 a.m. with DON B regarding resident 38's urinary catheter revealed: *Resident 38's care plan did not get updated after his urinary catheter was discontinued on 6/12/25. *She stated the nurse should have updated his care plan after they had received the order to discontinue it. Interview on 7/31/25 at 2:10 p.m. with director of nursing (DON) B regarding resident care plans revealed: *She expected resident care plans to be updated anytime there was a change in a resident's care or condition. *The nurses were able to update care plans in addition to all the management staff. *No one was currently completing audits of the care plans to ensure they were accurate. *She was aware the care plans were not up to date and some of the information in them were not up to date. *She verified there was conflicting information in resident 5's care plan which included, -Within the bowel and bladder focus area it indicated resident 5 was to wear a pull-up for incontinence and a panty liner for urinary leakage. -Within the ADL focus the care plan indicated resident 5 had the tendency to walk without a wheelchair or walker and she was independent with ambulation in her room. -Within the bowel and bladder focus area it indicated resident 5 needed assistance with toileting, and within the ADL focus area the care plan indicated she was independent with toileting. -The care sheet indicated she did not wear any	F0657		

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F0657 SS = E	Continued from page 4 incontinence product, and staff should walk with her in the hallway when she was restless. -The care sheet did not that she primarily used a wheelchair for locomotion. 4. Interview on 7/31/25 at 10:28 a.m. with licensed practical nurse (LPN) H revealed she did not know how to update resident care plans, and she did not know how to update care plans. 5. Review of the provider's care plan policy dated 11/2024 revealed: *" It is the philosophy of Avera [long term care] LTC to communicate effectively with all staff providing care for our residents. By ensuring a standardized careplan [care plan] process we are ensuring staff is getting the needed information for [the] resident's care." *"Policy Implementation: 5. iii. Only licensed professionals and designated ancillary department leaders will have access to make any changes to a resident's plan of care. This includes but is not limited to adding or deleting interventions from the worklist and adding or editing or frequencies on said interventions."	F0657		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, the provider failed to have a physician order for two of two sampled residents' (12 and 38) use of continuous positive airway pressure (CPAP) devices, which deliver pressurized air through a mask to keep a person's airways open. Findings include: 1. Observation and interview on 7/29/25 at 10:22 a.m. with resident 38 revealed:	F0658	Resident 12's order for CPAP device was placed on hold on July 30, 2025. Resident has been refusing use. Overnight oximetry was ordered to assess need for CPAP. Once testing is complete, order for CPAP/BIPAP will be initiated or CPAP will be considered for discontinue. Resident 38's order for CPAP/BIPAP was obtained on July 30, 2025 to reflect current settings along with cleaning and supply change interventions that are attached to the order in EMR. Policy was reviewed and updated on August 8, 2025. CPAP/BIPAP order and interventions were added to admission checklist on July 31, 2025, to assess for CPAP/BIPAP use and need for order and other interventions. All residents are potentially at risk. Education will be given to all nurses on CPAP/ BIPAP order and interventions by August 28, 2025 by DON or designee. Audits for CPAP/BIPAP order and interventions will be conducted monthly by DON, LPN Coordinator or designee. Audits will be discussed at monthly QAPI meetings and will be brought to the QAPI committee, quarterly, by the DON or designee for one year or until deemed no longer necessary by the QAPI committee. (continued)	August 28, 2025

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F0658 SS = D	Continued from page 5 *He had a CPAP machine that he cleaned himself. He stated, “I am going to as them [the staff] to do it because I think it could use a women’s touch.” 2. Interview on 7/30/25 at 8:10 a.m. with director of nursing (DON) B revealed they did not have a CPAP policy. She stated they did not have a current CPAP cleaning process but they were working on one. *She stated the current CPAP machines in the facility were newer and were cleaned in self-cleaning devices. *She stated the certified nursing assistants (CNAs) had been trained on the CPAPs by the family of a previous resident, but a newly contracted travel CNA had not been trained. 3. Interview and observation on 7/30/25 at 8:49 a.m. with CNA L revealed: *She demonstrated how resident 38’s CPAP mask went into the “SoClean” automated CPAP cleaning and sanitizing machine's tank in his room after it was removed from his face. *She stated, "I just hit the “on” button and it cleans and sanitizes his mask." She was not sure how often or when his CPAP device was to be cleaned. She stated the nurses cleaned the CPAPs. She stated there was one other resident with a CPAP machine. 4. Review of resident’s 12s EMR revealed her care plan indicated she used a CPAP device but there was not a medical order for that CPAP device. 5. Review of resident 38s EMR revealed his care plan indicated he used a CPAP device but there was not a medical order for the CPAP device. 6. Interview on 7/31/25 at 11:35 a.m. with certified medication aide (CMA) I revealed she had been trained how to use the CPAP devices automated cleaning system but she did not remember who trained her or when. She thought that CPAP training was part of her new staff orientation process and yearly competency reviews. 7. Interview on 7/31/25 at 11:38 a.m. with LPN H revealed she had been trained how to use the CPAP devices but could not remember who trained her or when. She thought it had been trained probably more than a year ago since she had received any CPAP training. 8. Interview on 7/31/25 at 10:04 a.m. with DON B regarding what professional standard reference she used	F0658	Continued from page 5 Resident 38's CPAP cleaning procedure was updated according to user manual on August 5, 2025. SoClean cleaning machine use was discontinued. Supply change frequency was clarified with DME provider on August 4, 2025. Ordered interventions for cleaning and supply change are attached to CPAP/BIPAP order in EMR order. Resident 38 and family was educated on the need for cleaning procedure to be according to the user manual on August 5, 2025. Education and competencies on daily cleaning, weekly cleaning and changing of supply frequency will be provided to nurses, med aides and CNA's by Infection Prevention nurse by August 28, 2025. Education will be added to new hire Infection Prevention Orientation. Audits for daily and weekly cleaning will be conducted 5 times a month by Infection Prevention Nurse or designee for 6 months. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI and reviewed for one year or until deemed no longer necessary.	

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F0658 SS = D	Continued from page 6 revealed: *She stated she would have used the manufacturing guidelines for new equipment or for the current CPAP devices. *She stated she she did not have a physician order policy but had a checklist process for physician orders that the nurses followed. *There were 3 lists the nurse could use for new order, admission, or return from hospital. *She agreed that CPAP was not on any of the 3 lists for a nurse to check off that a resident had that device or that the nurse had obtained a physicians order for that devices use for a resident.	F0658		
F0689 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), interview, record review, and policy review, the provider failed to ensure a safe environment by not having checked the coffee temperature to ensure it was within a safe temperature range before serving it to one of one sampled residents (9) who spilled her coffee and sustained a burn to her upper anterior (front) thighs. Findings include: Review of the provider's 5/21/25 SD DOH FRI report revealed that resident 9 had spilled her coffee in her lap at a meal on 5/16/25. Findings include: 1. Resident 9 had picked up her cup from the table and	F0689	Resident 9 was assessed as having no risk factors on March 13, 2025, prior to hot coffee spill on May 16, 2025. Hot liquids were served with a lidded cup starting May 16, 2025 and resident 9 was offered vinyl backed clothing protectors which she refused. Coffee pot was removed from resident 9's table on May 16, 2025. Dietary marked resident 9's table spot with an orange circle sticker marked with an "H" on May 19.2025. An orange dot was also added to her dietary card and select menu at that time. Low temp kit installation took place on May 20, 2025 to turn down tank temperature to 160 degrees. Dietary temped hot beverages starting on May 17, 2025 until June 7, 2025 as per advised by machine company. Hot beverages being temped started again on July 31, 2025 for every meal and afternoon snack time. All residents are potentially at risk. Dietary manager educated on need for temping hot beverages by Administrator on July 31, 2025. Policy developed by interdisciplinary team. Hot beverages procedure was changed for hot beverages to be temp checked at every meal and documented on temp log. Hot Beverages Assessment Tool was updated and was completed on all residents. Hot Beverage Assessment Tool will be completed on admission, quarterly, with significant changes and with any hot beverage spill by nursing staff or MDS nurse. Interventions will be initiated according to policy and resident care needs. Nursing, dietary, activity staff will be educated by dietary manager, DON or designee. Hot liquids in-service will be completed by August 28, 2025. Resident and/or family will be mailed education on Hot Beverage Policy by August 28, 2025. Audits will be conducted on hot beverages temping by Dietary Manager or designee 2x weekly x 4 weeks then monthly x 4. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by Dietary Manager or designee and reviewed for one year or until deemed no longer necessary.	August 28, 2025

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F0689 SS = G	Continued from page 7 it caught on her meal container, tipping the coffee into her lap. She wheeled herself out of the dining room. One of her tablemates notified the activities director (who is also a CNA) who had been in the dining room, and found resident 9 attempting to enter the lobby restroom and immediately assisted her in getting the wet clothing away from her skin. The resident suffered burning and blistering to her upper anterior (front) thighs. 2. Review of DON B's notes regarding the incident revealed that the coffee maker tank was set to a temp of 180 degrees and the staff had checked the coffee temperature and it was 168 degrees. 3. Interview on 7/29/25 at 8:37 a.m. with food service worker II (FSW II) R revealed that his position held the primary responsibility for filling the coffee carafes. He had not been instructed to take the temperatures of hot beverages or on what a safe serving temperature would be. He stated that after the 5/16/25 burn from hot coffee, they left the coffee carafe open in the kitchen for a few minutes in order to cool the coffee, and then they got a new coffee machine. They did not check the temperature of the coffee carafe after leaving it open. *Interview on 7/29/25 at 10:21 a.m. with resident 9 revealed that she burned her legs when she spilled her coffee in her lap. She said it was painful at the time but it healed up quickly. She stated that it was an accident, and anyone could spill their coffee. She thought there had been "too much fussing about it" and she had been embarrassed by it. *Interview on 7/29/25 at 12:00 p.m. with FSW II Q revealed her FSW II position was responsible for delivering meals to residents in the dining room but was not responsible for serving hot beverages. She had never checked the temperature of the hot beverages and did not think it was a part of the provider's regular food temperature monitoring and recording process. *Interview on 7/29/25 at 2:40 p.m. with certified dietary manager (CDM) P revealed that they had not taken the temperatures of hot beverages (coffee, hot water, hot chocolate) before serving them to the residents. The coffee machine supplier had installed a "low temp kit" on the coffee maker on 5/20/25 that was to limit the coffee temperature. They checked and recorded the temperature of the coffee from 5/17/25 to 6/7/25. Those temperatures ranged from temperature ranging from 145 to 156 degrees Fahrenheit (F). A new coffeemaker was installed on 6/24/25 with	F0689		

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F0689 SS = G	Continued from page 8 software-controlled temperatures that was to ensure that coffee and hot water could not dispense out of the machine if it was over 160 degrees F. They had not taken any temperatures of the coffee since that new machine was installed. *Interview on 7/31/25 at 1:30 p.m. with CDM P revealed that she was not aware that director of nursing (DON) B's notes of the above incident's investigation stated that the coffee dispenser tank was set at 180 degrees F and that dietary staff had temped the coffee at 168 degrees F. She did not know who might have provided those temperatures to the DON. She stated that she had instructed the staff to check the coffee temperature to ensure it had cooled to 150 degrees F before serving. She thought a safe temperature for serving hot beverages was be 160 degrees F. *Interview on 7/31/25 at 2:00 pm. with DON B revealed she thought the 180 degrees F coffee temperature in her notes had come from the coffee machine supplier. She could not identify who had temped the coffee at 168 degrees F. *Review of resident 9's electronic medical record (EMR) revealed that she was admitted on 6/2/23 with a primary diagnosis of dementia. Her Brief Interview for Mental Status (BIMS) assessment score was 7 which indicated she had severe cognitive impairment. *Her 3/13/25 hot liquid risk screening indicated no safety risk factors related to hot liquids. On 5/16/25, nurse practitioner (NP) A ordered Silvadene cream and dressings to the burn site. Resident 9's family member was notified of the incident and requested that she have a burn wound consultation. An e-care wound consultation (visit with a medical provider through the use of live video) was completed with no changes to treatment recommended. Wound inspection of resident 9 on 5/23/25 indicated that skin area remained red, measured 8.5 cm x 3.5 cm, and was dry. It required no further treatment. *Review of the provider's 10/31/24 LTC Falls and Accidents Policy revealed that "staff will ongoingly assess the physical environment with regard to potential hazards, including access to…hot liquids" and "any deficiencies in the safety of the physical environment will be immediately addressed." *Review of the provider's 5/22/24 LTC Food Safety and Sanitation Policy revealed "the serving temperature of hot beverages (coffee, tea, water) should be adjusted based on assessment of risk in order to decrease risk	F0689		

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F0689 SS = G	Continued from page 9 of resident burn."	F0689		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on Payroll Based Journal (PBJ) reports review, interview, posted nurse schedule review, and staff timecard review, the provider failed to ensure a registered nurse (RN) had been scheduled for eight consecutive hours of coverage for ten days in quarter four (Q4) (July 1 through September 30) of fiscal year 2024, and for seven days in quarter one (Q1) (October 1 through December 31) of fiscal year 2025. Findings include:	F0727	RN Waiver application was submitted to the SD Department of Health on August 1, 2025 and communication was received back that the application had been received. All residents are potentially at risk. 8 hour RN coverage will be scheduled August 28, 2025 through date RN waiver is approved. Administrator will educate DON on requirement of 8 consecutive hours of RN coverage daily or the need for yearly RN waiver if staffing not available by August 28, 2025. Administrator will educate nursing staff on need for consecutive 8 hour RN coverage 7 days a week and the need to replace RN with RN in the case of call-ins until waiver is obtained. Audits of the schedule for 8-hour RN coverage will be conducted by DON or designee weekly until waiver communication received and will re-evaluate at that time. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by Dietary Manager or designee and reviewed for one year or until deemed no longer necessary.	August 28, 2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA OAHE MANOR	700 E GARFIELD , GETTYSBURG, South Dakota, 57442

(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
F0727 SS = F	Continued from page 10 1. Interview on 7/29/25 at 8:48 a.m. with director of nursing (DON) B during the entrance conference revealed she thought the provider had a registered nurse (RN) staffing waiver in place that exempted them from the requirement of having an RN in the facility for eight consecutive hours seven days a week. 2. Review of the provider's RN waiver application revealed: *The provider had an RN waiver in place that required to have been reapproved by 7/10/24. *The provider sent an email to the South Dakota Department of Health (SD DOH) to reapply for the RN waiver on 5/16/25. *On 6/5/25 the SD DOH replied to the provider's application with direction from the Center for Medicare and Medicaid Services (CMS) to, "wait on the waiver review and approval until after the facility's next recertification survey." 3. Review of the provider's nurse staffing schedule for 7/20/25 through 8/9/25 revealed there was no RN scheduled on 7/26/25. 4. Review of the RN staff timecards for Q4 fiscal year 2024 and Q1 fiscal year 2025 revealed: *RN coverage for eight consecutive hours could not be verified for 7/19/24, 7/20/24, 7/21/24, 7/27/24, 8/16/24, 8/17/24, 9/7/24, 9/8/24, 9/28/24, and 9/29/24 in Q4 of fiscal year 2024. *RN coverage for eight consecutive hours could not be verified for 10/19/24, 10/27/25, 11/10/25, 11/28/25, 12/21/25, 12/22/25, and 12/23/25 in Q1 of fiscal year 2025. 5. Interview on 7/30/25 at 8:11 a.m. with DON B revealed the provider did not have a staffing policy. 6. Interview on 7/31/25 at 9:00 a.m. with administrator A and DON B revealed: *Administrator A was responsible for submitting the application to the SD DOH for the RN staffing waiver request. *Administrator A was not aware the RN staffing waiver had been due for renewal on 7/10/24.	F0727		

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F0727 SS = F	Continued from page 11 *Administrator A realized there was a lapse in the RN staffing waiver in May 2025, when she submitted the letter to renew the waiver. *Even after the lapse in the waiver was identified Administrator A, DON B stated she was not aware an RN needed to be in the facility for eight consecutive hours seven days per week. *DON B verified there were days in Q4 fiscal year 2024, and Q1 fiscal year 2025, that there was no RN in the facility for eight consecutive hours. *She stated there were days in the provider's current schedule that did not have an RN scheduled for eight consecutive hours.	F0727		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F0880	CNA J, CNA K, CNA M, RN F, RN G, and Housekeeper N will be educated on Transmission Based Precautions, which includes Isolation Precautions and Enhanced Barrier Precautions by August 28.2025. They will also be educated in Disinfection of Non-Critical Resident Care Equipment and hand hygiene. TBP, hand hygiene and disinfection of shared equipment education was provided to all staff including; nursing, housekeeping, laundry, dietary, activity and physical therapy at mandatory all staff meeting on August 13, 2025. Education and policies will be given to new hires by the IP nurse. Audits on hand hygiene, TBP and disinfection of share equipment will be conducted weekly for three months then monthly for 4 months by the IP nurse or designee. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by IP Nurse or designee and reviewed for one year or until deemed no long necessary. All residents are potentially at risk. Policy was reviewed with no identified updates needed on August 18, 2025 by IP nurse.	August 28, 2025

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F0880 SS = E	Continued from page 12 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled:Number of residents cited: Based on observation, interview, and policy review the provider failed to follow infection control practices to ensure: *Enhanced barrier precautions (EBP) (glove and gown use	F0880		

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F0880 SS = E	Continued from page 13 when providing contact care) and contact precautions (gown and gloves must be worn when entering a resident's room to prevent the spread of an identified organism) were properly followed for two of two sampled residents (3 and 26). *The sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) slings were not shared or properly disinfected between residents (4 and 17) use. Findings include: 1. Observation on 7/29/25 at 9:38 a.m. of resident 3's room revealed: *A sign on the outside of his door indicated the need for contact precautions. *Personal Protective Equipment (PPE) was hanging on the door across the hall from resident 3's room. Review of resident 3's electronic medical record (EMR) revealed: *He had a left knee abscess that was drained on 1/27/25. -The culture obtained during the abscess being drained was positive for methicillin-resistant staphylococcus aureus (MRSA) (a contagious antibiotic-resistant infection). *He had a 4/3/25 physician order for a dressing change to an open wound on his left knee. *His 7/30/25 care plan indicated he was on contact precautions due to an open wound on his left knee that had been cultured positive for MRSA on 1/27/25. Observation and interview on 7/29/25 at 10:38 a.m. outside resident 3's with certified nursing assistant (CNA) J revealed: *CNA J exited resident 3's room with the sit-to-stand lift and placed the lift in the hallway without disinfecting the lift. *She had a gown and gloves on when she exited the room. *She walked across the hallway to the tub room and removed and discarded her gown and gloves.	F0880		

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F0880 SS = E	Continued from page 14 *She applied another pair of gloves without performing hand hygiene (handwashing). *She pushed resident 3's wheelchair into the hallway from the tub room. *CNA J then cleaned the sit-to-stand lift with a disinfectant wipe. *Resident 3 was seated in his recliner in his room. *CNA J stated resident 3 was on contact precautions because he had a wound on his knee that had previously tested positive for MRSA. Observation on 7/29/25 at 11:08 a.m. of housekeeper N in resident 3's room revealed: *She was mopping resident 3's room floor. *She was not wearing a gown or gloves, which would have been required for a resident who was on contact precautions when she entered the resident room. Interview on 7/31/25 at 1:30 p.m. with housekeeper N revealed: *The cleaning of a resident's room consisted of wiping down all the surfaces in the room, cleaning the toilet, and mopping the floor daily. *A deep cleaning of each resident's room, which included dusting and cleaning the registers was completed weekly. 2. Observation on 7/29/25 at 9:38 a.m. of resident 26's room revealed, there was a green square posted on the door frame at the entrance to her room, and PPE was hanging on the back of her room door. Interview on 7/29/25 at 10:44 a.m. with CNA J revealed: *The green square on the door frame indicated the resident was on enhanced barrier precautions (EBP). *Resident 26 was on EBP for a history of MRSA. *Resident 26 did not have an open wound. 3. Observation on 7/29/25 at 9:44 a.m. in the Haven secured dementia unit's common area revealed, several wheelchairs were lined up against the wall. Four of those wheelchairs had a sit-to-stand lift sling draped over the back of the wheelchair.	F0880		

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F0880 SS = E	Continued from page 15 Observation on 7/30/25 at 11:42 a.m. in the Haven common area revealed: *There was a sling draped over the sit-to-stand mechanical lift. *Registered nurse (RN) G and CNA K used a second sit-to-stand lift sling to assist resident 17 from the recliner to his wheelchair. *CNA K then placed that sit-to-stand sling on top of the other sling that was draped over the mechanical lift. *She wiped the bars on the sit-to-stand that the resident holds on to and the arms that support the lift sling with a disinfectant wipe but did not clean any other surfaces of the lift or change the lift sling. *The sit-to-stand sling was made of cloth material, which would not maintain the wet contact time required with the use of disinfectant wipes to ensure the sling was disinfected between each resident use. *CNA K then used the lift sling used for resident 17 for assisting resident 4 from a recliner to his wheelchair with the sit-to-stand lift. *CNA K then draped the sit-to-stand lift sling back over the lift. *CNA K wiped the bars on the sit-to-stand that the resident holds on to and the arms that support the lift sling with a disinfectant wipe but did not clean any other surfaces of the lift or change the lift sling. *No hand hygiene was completed before, during, or after the above residents' transfers. 4. Interview on 7/31/15 at 10:04 a.m. with CNA M revealed: *All residents were to have their own sit-to-stand sling. *The slings were to be cleaned weekly and as needed by laundry. *The sit-to-stand lifts were to be wiped down after each resident use. *She was not aware of any resident in the Haven area	F0880		

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F0880 SS = E	Continued from page 16 who was on EBP. *She wore PPE when providing any close contact cares with resident 26. *She wore PPE when she assisted resident 3 to the bathroom or changed his clothing. 5. Interview on 7/31/25 at 10:18 a.m. with RN F revealed: *All residents were to have their own sit-to-stand slings. *The sit-to-stand lift was to be wiped down after each resident use. *EBPs were to be implemented with any resident who had a urinary catheter, a wound, or a history of an MDRO (multidrug resistant organism). *Residents 3 and 26 were on EBP due to having a history of MRSA. *Staff were to wear a gown and gloves with resident 26 anytime she was in the bathroom or with bedding changes because she was often incontinent of urine. *PPE was to be worn when the staff completed dressing changes for resident 3. 6. Interview on 7/31/25 at 12:20 p.m. with RN/infection preventionist C revealed: *Each resident was to have their own sit-to stand lift sling. *The sit-to-stand lift was to be wiped down with a disinfectant after each resident use. *PPE should be worn when providing most resident cares, such as toileting, changing clothes, changing bedding, bathing, and transferring residents on EBP. *PPE should be worn anytime a staff member entered the room of a resident on contact precautions. *She expected housekeeping to wear PPE when cleaning a room of a resident on contact precautions if their clothing could come in contact with any of the room surfaces. *PPE should be removed prior to exiting a resident's room who is on contact precautions.	F0880		

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F0880 SS = E	Continued from page 17 7. Interview on 7/31/25 at 2:10 p.m. with director of nursing (DON) B revealed: *PPE should be worn with residents on EBP anytime staff would come into contact with the resident. *PPE should be worn with residents on contact precautions anytime staff come in contact with the resident. *PPE should be removed prior to the staff member exiting the resident's room. *She expected the housekeeping staff to wear PPE when cleaning a resident's room who was on contact precautions. *Each resident should have had their own sit-to-stand sling. *The sit-to-stand lift should have been cleaned after each resident use. Review of the provider's 11/13/24 Transmission Based Precautions and Enhanced Barrier Precautions policy revealed: *Purpose: -"A means of transmission for the organism. --Interruption of this link in the chain of infection is achieved primarily by separating an individual physically (Transmission Based Precautions) or using a barrier (Enhanced Barrier Precautions)." *"Enhanced Barrier Precautions are used during high contact resident care activities for the following residents and should be implemented as facilities are able: -a. Infection of colonization with an MDRO when contact precautions do not otherwise apply….. -d. if a, b, or c apply, gown and gloves must be used during high contact resident care activities including (but not limited to) --i. dressing --ii. bathing --iii. transferring	F0880		

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F0880 SS = E	Continued from page 18 --iv. providing hygiene --v. changing linen --vi. changing briefs or assisting with toileting --vii. device care or use (Central lines, urinary catheters, feeding tube, trach [tracheostomy] adjustment/care --viii. wound care (any wound requiring a dressing) --ix. Therapy requiring resident contact with uniform” *“Remove PPE appropriately and complete hand hygiene before leaving the room”. *“Contact Precautions will be used for residents with known or suspected infections due to certain organisms. Examples are:…. -Active infection with MDRO”. *“Gowns: -a. Wear whenever anticipating that clothing will have direct contact with the resident or potentially contaminated environmental surfaces or equipment in close proximity to the resident. Don gown upon entry into the room if need is anticipated.” *“Gloves: -a. Wear whenever touching the resident’s intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails). Don gloves upon entry into the room if need is anticipated…… -c. Remove before leaving the room. ” -“Hand Hygiene upon entering and leaving the room and after removal of PPE.” Review of the provider’s October 2024 LTC [long term care] IC [infection control] Policy & Procedures policy revealed: *“Handwashing: Good hand hygiene techniques will be used before, during and after the care of each resident.” *“CLEANING DISINFECTION AND STERILIZATION OF EQUIPMENT	F0880		

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F0880 SS = E	Continued from page 19 -A. Non-Disposable Items:….. --5. All other equipment will be cleaned between use of each resident.”	F0880		

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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 7/29/25. Avera Oahe Manor was found in compliance.	E0000		
K0000	INITIAL COMMENTS A recertification survey was conducted on 7/29/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Oahe Manor was found not in compliance. Please mark an F in the completion date column for the K241 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K221 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0221 SS = D	Patient Sleeping Room Doors CFR(s): NFPA 101 Patient Sleeping Room Doors Locks on patient sleeping room doors are not permitted unless the key-locking device that restricts access from the corridor does not restrict egress from the patient room, or the locking arrangement is permitted for patient clinical, security or safety needs in accordance with 18.2.2.2.5 or 19.2.2.2.5. 18.2.2.2, 19.2.2.2, TIA 12-4 This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview the provider failed to ensure access to the corridor was not restricted for two randomly observed locations (resident rooms S-21 and E-4). Findings Include:	K0221	Room doors on rooms S-21 and E-4 were fixed as of August 22, 2025, to ensure access to the corridor. All residents are potentially at risk. All room doors were checked by maintenance and access to corridor verified on August 22, 2025. The administrator or designee will educate maintenance staff on the need for all doors to open easily to ensure access to the corridor by August 28, 2025. Maintenance will conduct four audits on resident room doors monthly for four months. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by Administrator or designee and reviewed for one year or until deemed no longer necessary.	August 28, 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 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
Rena Robbennolt CNP	Adminstrator	8/22/25

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA OAHE MANOR	700 E GARFIELD , GETTYSBURG, South Dakota, 57442

(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
K0221 SS = D	Continued from page 1 1. Observation and testing on 7/29/25 at 1:40 p.m. revealed the door to resident room S-21 would drag on the floor when closed. Due to that condition opening that door required a force greater than fifty pounds to set it in motion. Interview with the Maintenance Technician at that same time confirmed that finding. 2. Observation and testing on 7/29/25 at 2:09 p.m. revealed the door to resident room E-4 would drag on the doorframe when closed. Due to that condition opening that door required a force greater than fifty pounds to set it in motion. Interview with the Maintenance Technician at that same time confirmed that finding. He stated he agreed that door took too much force to open, he then added he was normally responsible for the attached hospital and the nursing home facility's maintenance staff person would be the one to know more about the facilities corridor doors	K0221		
K0241 SS = C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This STANDARD is NOT MET as evidenced by: Based on observation and document review, the provider failed to maintain acceptable exits from each floor level of the building. The basement storage area had only one exit. Findings include: 1. Observation on 7/29/25 at 1:00 p.m. revealed the basement storage area did not have the required number of acceptable exits. It had only one exit that discharged onto the main level corridor. The exterior exit discharge location was not apparent at the	K0241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A113	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/29/2025

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K0241 SS = C	Continued from page 2 corridor level location from the basement stair enclosure. The basement storage area was adjacent to the boiler room (a hazardous location) that could not be designated as an approved emergency egress path. Review of previous survey data confirmed that condition had existed since the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. This deficiency would not affect any of the residents and minimal staff within the facility.	K0241		

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
	10624	A. BUILDING: _____ B. WING _____	07/31/2025

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/29/25 through 7/31/25. Avera Oahe Manor was found in compliance.	S 000		
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 7/29/25 through 7/31/25. Avera Oahe Manor was found not in compliance with the following requirement: S206.	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	S 206	Employee O was assigned training on food handling and preparation, food borne illnesses, serving and distribution, leftovers, time and temperature controls, and sanitation in the online training program and was completed on August 21, 2025. Avera Staff Development was contacted about assigned learning. It was found that employee O was assigned learning for hospital cost center instead of long-term care cost center. New hire education for dietary department employees will be reviewed by Dietary Manager or designee upon hire to ensure the 9 required dietary in-service trainings are assigned and completed per regulation. Resident Care Director will educate the Dietary Manager on the 9 required dietary in-service training courses by August 28, 2025. Education audits will be conducted within 30 days of hire by Dietary Manager and monthly x 4 months to ensure required education completed. Audits will be discussed monthly at monthly QAPI meetings and will be brought to quarterly QAPI committee meetings by Dietary Manager or designee and reviewed for one year or until deemed no longer necessary. All residents are potentially at risk	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rena Robbennolt CNP	Administrator	8/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10624	A. BUILDING: _____ B. WING _____	07/31/2025

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S 206	Continued From page 1 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 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records, training transcript review, and interview, the provider failed to ensure six of nine required dietary inservice trainings were completed for one of five sampled employees (O) within 30 days of hire. Findings include: 1. Review of employee personnel records revealed employee O was hired on 4/28/25. 2. Review of employee training records and online training transcripts revealed, there was no documentation that employee O had completed training on food handling and preparation, foodborne illnesses, serving and distribution, leftovers, time and temperature controls, and sanitation. 3. Interview on 7/30/25 at 4:11 p.m. with human resources E and administrator A revealed: *The provider used an online training program for employee-required training. *Human resources E verified employee O had not completed the trainings on food handling and preparation, foodborne illnesses, serving and	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10624	A. BUILDING: _____ B. WING _____	07/31/2025

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S 206	Continued From page 2 distribution, leftovers, time and temperature controls, and sanitation within 30 days of hire. *Employee O had not been assigned the trainings on food handling and preparation, foodborne illnesses, serving and distribution, leftovers, time and temperature controls, and sanitation in the online training program.	S 206		