STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A113	A. BUILDING _____ B. WING _____	01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA OAHE MANOR	700 E GARFIELD GETTYSBURG, SD 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
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 1/23/24 through 1/25/24. Avera Oahe Manor was found not in compliance with the following requirements: F550, F655, and F909.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	Resident 82's Care Plan was updated by MDS coordinator C to reflect needs on comfortable positioning. Education on resident rights, dignity, choice and comfortable positioning will be provided to all staff by March 10, 2024. Audits for dignified and comfortable positioning will be conducted weekly by the DON or designee. The audits will be discussed at monthly QAPI meetings and will be brought to QAPI committee by the DON or designee for one year or until deemed no longer necessary by the QAPI committee.	March 10, 2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Livermont
TITLE: Administrator
(X6) DATE: 2.14.24 2.15.24

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.

Kristi Livermont

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F 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to offer or provide dignified positioning for one sampled vulnerable resident (82) while in the activity room. Findings include: 1. Observation on 1/24/24 at 9:40 a.m. of the front activity room revealed: *Resident 27 was seated in a chair at the table across from resident 82. *Resident 82 was positioned approximately 3 feet from the activity table in her wheelchair, slumped forward with her head hung over her knees, her arms hung down in front of her, and her hands resting on her ankles/feet by the front wheelchair pedals. *Activities assistant E was placing bingo cards on the activity table. *Activities coordinator F had then entered the room. *Shortly after, activities assistant G had entered the room. *All three staff sat at the opposite end of the table from the residents and had what appeared to be a meeting. *Resident 82 was noted to be in the same	F 550		

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AVERA OAHE MANOR	700 E GARFIELD GETTYSBURG, SD 57442

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F 550	Continued From page 2 position, with her head at her knee level, moving her left hand and lifting her head periodically. *None of these staff were observed to have acknowledged resident 82 or offer/request assistance for her to be repositioned in an upright position. 2. Observation on 1/24/24 at 9:49 a.m. revealed: *All three activities staff (E, F and G) exited the activities room. *Resident 82 remained in the same position, moving both of her hands, touching her feet, ankles and wheelchair legs and pedals, and attempting to lift her head. 3. Observation and interview on 1/24/24 at 9:53 a.m. revealed: *Resident 27 was sitting across from resident 82. She shook her head and stated she had to ask them [staff] to help her [resident 82]. *Resident 27 stated she was worried she [resident 82] was going to fall out of her chair. *Resident 82 was in her wheelchair positioned at the bingo table, slumped over with her right hand and head resting on the table. 4. Observation on 1/24/24 at 9:56 a.m. revealed activities coordinator F entered and exited the activity room, leaving resident 82 in the same position. 5. Observation on 1/24/24 at 10:02 a.m. revealed: *Activities coordinator F had returned with two other staff. *Those two staff assisted resident 82 from her wheelchair in the activities room to a recliner in the dining room with her feet elevated. *The resident closed her eyes and appeared to have fallen asleep.	F 550		

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F 550	Continued From page 3 6. Record review revealed resident 82: *Was admitted on 1/18/24. *Was admitted to hospice services on 1/19/24. *Had diagnoses of: -Parkinson's disease with dyskinesia, with fluctuations. -Dementia in other diseases classified elsewhere, severe, with psychotic disturbance. -Idiopathic scoliosis [curved spine]. -Weakness. -Anxiety disorder, unspecified. -Moderate persistent asthma. 7. Interview on 1/25/24 at 9:58 a.m. with administrator A and director of nursing B regarding vulnerable residents, including resident 82, revealed: *Staff should have approached the resident and assisted if they were appropriate to do so. *Staff should get nursing staff or use the radio to call for assistance. *All residents should get help in a dignified and timely manner. 8. Interview on 1/25/24 at 11:01 a.m. with activities coordinator F regarding the observations of resident 82 revealed she stated: *She should have checked to see if the resident was ok or needed assistance. *All staff should check on any resident who is seen in poor or unsafe positioning and assistance should be given or requested right away. 9. Review of the provider's last approved February 2023 Patient/Resident Rights and Responsibilities policy revealed: *"The patient/resident has the right to be treated with dignity, compassion and respect. The	F 550		

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F 550	Continued From page 4 patient/resident has the right to care that takes into account the social, spiritual and cultural matters that have an effect on his or her illness. Race, ethnicity, sex, culture, language, sexual orientation, gender identity, physical/mental disabilities, religion or ability to pay will not affect the care delivered." 10. Review of the provider's last approved April 2023 Resident Quality of Life policy revealed: *The provider "will promote care of each resident in a manner and in an environment that maintains and enhances each resident's dignity and respect while enhancing the resident's individuality." *"Staff provides care that maintains and enhances each resident's self-esteem and self-worth. This is carried out with each interaction staff have with each resident." *"While providing care to residents and/or during staff interaction(s), staff will promote resident dignity." *"Staff will provide care to residents in the above referenced areas (others as indicated) in a manner that recognizes the self-worth, dignity and respect of each resident."	F 550		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655	Admission nurse will provide resident and resident representative a written copy of medications within 48 hrs. of admission. Admission nurse will document in the EMR in the "Family/Responsible Notification" intervention. SSD will provide resident and resident representative written copy of baseline care plan within 48 hrs. of admission. SSD will document in the EMR in the "Family/Responsible Notification" intervention. Compliance of all new admissions will be monitored monthly by the SSD or designee, reported to QAPI committee quarterly for one year or until deemed no longer necessary by the QAPI committee.	March 10, 2024

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F 655	Continued From page 5 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on electronic medical record (EMR) review, interview, and policy review, the provider failed to ensure documentation in the EMR had indicated that three of three sampled residents (332, 182, and 82) had received their baseline	F 655		

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F 655	Continued From page 6 care plan. Findings include: 1. Review of resident 82, 182, and 332's EMR confirmed no documentation they had received a copy of their baseline care plan. Interview on 1/24/24 at 3:20 p.m. with director of resident care J regarding documentation of resident's receiving a copy of their baseline care plan revealed: *She agreed that their was no documentation that resident 82, 182, and 332 had received a copy of her baseline care plan. *Licensed practical nurse (LPN) H should have provided the copy of the baseline care plan to the resident and documented that it was given. Interview on 1/25/24 at 2:40 p.m. with LPN H regarding documentation of resident 182 and 82 had received a copy of their baseline care plan revealed: *She did not have documentation that a copy of the baseline care plan had been provided to the residents and representatives. *They would have printed a copy of the baseline care plan and provided it to the resident or representative, but they do not document that it had been given. Review of the provider's October 2023 Care Plan Procedure revealed: *"The plan of care is initiated within 48 hours after admission and fully developed within seven days following the comprehensive assessment, by the interdisciplinary team."	F 655		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3)	F 909	Care Plans for 332 and 27 were reviewed and revised on 1/25/24 by LPN, H. Order was received for side rail, intervention "Mobility/Positioning/Safety Device Eval" was added to both resident's work list, with frequency set to every 90 days, and consent was signed. ½ side rail notation was added to facility Care Sheet by LPN H.	March 10, 2024

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F 909	Continued From page 7 §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, electronic medical record (EMR) review, and policy review the provider failed to ensure two of two sampled resident's (332 and 27) had a physician's order, assessment, consent, care planned, and inspection of the side rails they had been using. Findings include: 1. Observation and interview on 1/23/24 at 10:43 a.m. with resident 332's regarding the use of her side rail that was raised at the head of her bed revealed she used the side rail for bed mobility. Review of resident 332's EMR revealed: *On 1/8/24 a device evaluation was completed and was marked no for currently using a device to assist with mobility/positioning/safety. *No physician's order, consent, or care plan had indicated the use of the side rail. 2. Observation and interview on 1/23/24 during the initial tour revealed resident 27: *Had one side rail in the up position near the head of the bed, on the left side. *Resident stated she uses it to move herself around in bed. Interview on 1/24/24 at 3:44 p.m. with LPN H regarding request for resident 27's side rail	F 909	1/25/24 LPN, H added intervention "Mobility/Positioning/Safety Device Eval" to every resident's worklist. LPN H set frequency to Q90days. She evaluated every resident room to determine if side rail was being used. If a side rail was in use, she obtained an order and consent was signed. LPN H updated the Care Plans and our facility Care Sheet. 2/13/24 LPN, H placed stickers on head of beds that read "1/2 side rail" on residents that have orders and consents for side rails in place. DON or designee will educate all staff on sticker process by March 10, 2024, and instruct that if any side rail is found up that does not have a sticker on it, or if a resident or family member requests side rail be put up, staff will explain they have to inform the charge nurse or LPN resident care coordinator to make this change. 2/13/24 LPN, H also updated facility admission checklist to include reminder to add the "Mobility/Positioning/Safety Device Eval" to all admissions, to be done on admit and Q90days. 2/7/24 Restraint education was presented at All Staff Meeting by RN, B. DON or designee will verify weekly there is documentation of the assessment for need and use of the side rail, an order and consent in the electronic medical record, and the side rail is care planned and on our facility Care Sheets. DON or designee will conduct weekly audits of all resident rooms to ensure if a side rail is up, there is a sticker on the head of bed. DON or designee will audit monthly for quarterly review of continued need. Maintenance or designee will assess/inspect side rails annually. The audits will be discussed at monthly QAPI meetings and will be brought to QAPI committee by the DON or designee for one year or until deemed no longer necessary by the QAPI committee.	

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F 909	Continued From page 8 revealed she: *Had not been aware of resident 27's side rail. *Stated there was not an assessment, order or consent for resident 27's side rail. Review of resident 27's EMR revealed there was no physician's order, assessment, consent, or care plan for the use of a side rail. Interview on 1/25/24 at 10:30 a.m. with maintenance technician I regarding the inspection of the side rail when attached to a resident's bed revealed: *All but four of the beds with side rail had been in use upon his employment in 2019. *He had not been inspecting the bed with side rails annually. Review of the provider's April 2023 Siderail Policy revealed: *"If side rails are in use, the resident will have a dated, timed order from the provider with the rational for the side rail use. The resident will be assessed and care planned for the side rail and the family will sign a consent for the side rail use." *"Use of side rails will be reevaluated at every provider visit and quarterly with care plans." Review of the provider's April 2023 Restraint Policy revealed: *"Staff will fill out the side rail/grab bar intervention and ADL intervention prior to side rail utilization to assess bed mobility." *"Results of resident's bed mobility needs will be reviewed by interdisciplinary team, resident/family, and resident's physician. Designated interdisciplinary team members will assist in evaluation the resident's cognitive status as the interdisciplinary team determines the	F 909		

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F 909	Continued From page 9 resident's full ability to make a safe decision regarding the side rail usage." *"Prior to utilizing side rails a pre-retraining assessment will be completed to ensure resident's safety of the device." *"A physician's order must be obtained for the use of the side rails." *"Use of device will be care planned accordingly and quarterly assessment will be documented in the restraint assessment." *"Staff will document on side rail usage every shift. This information will be charted on the Side/Rail Grab Bar intervention in the EHR." *"Use of the device will be reviewed quarterly by Interdisciplinary team, resident, and family at the care conference."	F 909		

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E 000	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 from 1/23/24 through 1/25/24. Avera Oahe Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Livermont
TITLE: Administrator
(X6) DATE: 2.14.24

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.

South Dakota Department of Health

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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 1/23/24 through 1/25/24. 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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/23/24 through 1/25/24. Avera Oahe Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Livermont | TITLE: Administrator | (X6) DATE: 2.14.24