PRINTED: 02/06/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING С B. WNG 43A137 01/30/2024 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **501 NORTH 4TH STREET** AVERA BORMANN MANOR PARKSTON, SD 57366 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 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 on 1/30/24. The area surveyed was accidents. Avera Bormann Manor was found not in compliance with the following requirements: F600 and F658. F 600 F 600 Free from Abuse and Neglect SS=G CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced

1. Review of the SD DOH online report revealed

*On 1/20/24 restorative aide F applied a warm pack on the back of resident 20's neck.

SD DOH-OLC

Based on review of the South Dakota Department of Health (SD DOH) online report, observation, record review, interview, and policy review, the provider failed to ensure one of three sampled residents (20) received appropriate care

to prevent a burn from a warm pack.

by:

the following:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Kummer	LTC Administrator	02/13/24
Any deficiency watement ending with an asterisk (*) denotes a deficiency which the institution may be of other safeguards provide sufficient protection to the patients: (See instructions.) Except for nursing ho following the date of survey whether or not a plan of correction is provided. For nursing homes, the abu days following the date these documents are made available to the facility. If patienticies are cited, an program participation.	omes, the findings stated above are disclosable 90 (ove findings and plans of correction are disclosable	days e 14
FORM CMS-2567(02-99) Previous Versions Obsorete FEB 1 3 2024Event IC: DE0711 Fac	cility ID: 0068 If contin	nuation sheet Page 1 of 10

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/06/2024 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NOF CORRECTION UMBER:		(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/30/202	
		43A137					
	Rovider or Supplier Ormann Manor			50	REET ADDRESS, CITY, STATE, ZIP CODE 1 NORTH 4TH STREET IRKSTON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X6) COMPLETION DATE
F 600	-The warm pack was wrapped in Chux (dis pad). -Resident 20's cogniti Observation and inter p.m. resident 22 in his *He was seated in a E wheelchair] chair. *He made no eye com respond coherently to Review of resident 20 revealed his: *12/27/23 Brief Intervi was a 4, meaning he *Diagnoses Included / Lewy Body dementia and anxiety. *Medication administra 1/20/24 physician order (Silvadene 1%) to the burn. *Care plan included th -"Resident blank stare unresponsive to family- "Staff will anticipate in -"Chronic Pain-as evic headaches, GERD [ga disease], monitor for f nonverbal s/s [signs a -He required the assis for most activities of d Interview on 1/30/24 a aide (RA) F regarding report revealed:	a heated wet hand towel posable waterproof-under ion score was a 4. view on 1/30/24 at 12:22 s room revealed: Broda [a specialized ntact, and was unable to o questions. Vs electronic medical record iew of Mental Status score was cognitively impaired. Alzheimer's Disease and with behavioral disturbance, ation record included a er for Silver Sulfadiazine right side of the neck for a he following: es and is verbally y and staff." heeds." denced by: hx [history] of astroesophageal reflux acial grimacing and nd symptoms] of pain." stance of two staff members ally living.	F		 All nursing and restorative nursing staff were notified of 1/24/24 to discontinue use of any warm packs on residen and also on all residents wh are cognitively incapable of communicating needs. The warm pack policy and procedure in use at the time the incident has been discontinued. The nursing staff and restor staff will now apply blankets towels warmed in a comment warmer (set to 130 degrees per manufacturer guidelines injury prevention) to residen requesting heat application. The policy and procedure for heat therapy has been chan to reflect warm blanket/tower use. This policy and procedure will be followed by the nursin and restorative nursing care staff. All nursing and restor care staff will be trained on the new policy by 2/21/24. All nursing and restorative of staff will also be trained on the preparation and application warm blankets/towels. This training will be given by the and/or designee. This trainin will also be completed by 2// The charge nurse will be responsible for checking and documenting the temperatur the towel warmer once per staff. 	of t 20 oo of ative or cial F for ts or ged l ure ng ative he of the DON ng 21/24.	2/21/2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	ERS FOR MEDICARE & MEDICAID SERVICES TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPI	E CONSTRUCTION		SURVEY
	of deficiencies F Correction				COMPLETE	
		43A137	B. WING		1	30/2024
IN US OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VAME OF P				501 NORTH 4TH STREET		
AVERA B	ORMANN MANOR			PARKSTON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE AGTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 600	 -Had worked as the R -Had previously worked year or two a few year *She had started place residents' necks beford nursing care to help to muscles. -She had no training it -She had no guidance therapist in the use of -Warm packs were here for 30 seconds. *On 1/20/24 she had the microwave and sh -Took two of the warm resident 21 and reside. -Thought the third wa -Then placed the third wa -That warm pack shee plastic side out, and president 20's neck, wa -She had not "thought cause a burn)." Interview on 1/30/24 an ursing assistant (CN warm packs revealed *CNAs did not use wa *RA F and nurses had care. Observation and inter p.m. of resident 20 wirevealed: *The mid-back of resident of eschar (a collection) 	A for about three months. ed for the provider for a "a rs ago". ing warm packs on re completing the restorative posen the residents' neck in the use of warm packs. e from a nurse or physical warm packs. bated up in the microwave heated three warm packs in ne: n packs and placed them on ent 22's necks. I'm pack had cooled. I warm pack back in the ed It for another 30 e wrapped in a Chux with the placed on the back of as "not on for 20 minutes." t it would get that hot (to at 12:38 p.m. with certified A) G regarding the use of	F 60	 5. Director of nursing or de will audit/observe heat the application to ensure the policy/procedure is follow residents who have curre orders for warm packs/h therapy. Each application heat therapy will be audit daily X 7 days. Results audits will be presented quality assurance comm 2/20/24. The QA commindetermine if further audit needed. The temperature docum will also be audited daily weekly X 1 month and m months to assure the ch is checking and docume temperatures per policy. will be presented to the Grommittee on 2/20/24. The results of the first will be presented to the Grommittee on 2/20/24. The auditing will be presented to the Grommittee on 2/20/24. The temperature docume temperatures per policy. Will be done by DON or Or The results of the first will be presented to the Grommittee on 2/20/24. The March QA meeting a monthly audits will be presented the March QA meeting a monthly audits will be presented the April, May, an QA meetings. 	nerapy e new ved for ent eat on of ted of the to the ittee on ittee will ing is entation X 7 days, nonthly X 3 arge nurse nting Auditing designee. eeks audit QA The weekly d during end the esented	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/06/2024 FORM APPROVED OMB NO, 0938-0391

STATEMENT	NTERS FOR MEDICARE & MEDICAID SERVICES IMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE ((X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A, BUILDI			COMP	LETED
							C
		43A137	B. WNG			01/	30/2024
NAME OF P	ROVIDER OR SUPPLIER	ð 100 million		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				50	1 NORTH 4TH STREET		
AVERAB	ORMANN MANOR			PA	RKSTON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 600	neck were two areas size of dimes. *RN D stated those e from a warm pack bu -CNAs and RA F were residents that were of tell them if the warm p -She was not certain CNAs and RAs in the -She thought the RA use them, as "she ha restorative." Interview on 1/30/24 a regarding the use of v revealed: *On 1/20/24 she obse after staff notified her -The back of his neck blistered. She placed a cool p medical provider. *She stated the area had some eschar tiss warm pack had been *Warm packs were or were cognitively awar packs were "too warn *She was not certain RAs in the use of war Interview on 1/30/24 a administrator A regard and restorative nursir *There was not a rest program for staff. -CNAs were trained,	ght side of the back of his- of eschar the approximate schar areas were caused rn on 1/20/24. e able use warm packs on ognitively aware and could pack was too hot. who would have trained e use of warm packs. F would have known how to d been trained in at 12:56 p.m. with RN C warm packs for residents erved resident 20's neck of a possible burn. t was red, was not raised, or ack on it and called his had not become open and ue on the area where the placed. hy used on residents who re and could say if the warm n". who had trained CNAs and m packs. at 1:06 p.m. with ding the use of warm packs	F	500	6. A physicians order will be obtained for all residents a warm towel. An order PRN application of a wattowel will be added to out admission orders for all residents. The charge n may assess a resident for and direct the other nurs restorative staff to apply towel for that resident. An audit will be complete DON or designee to ass residents currently using towels have a physician The results of this audit reviewed at the QA mtng on 2/20/24.	using for the rm future urse or pain ing or a warm ed by ure all warm s order. will be	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 09	38-03
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SUR COMPLETE	
		43A137	B. WING			C 01/30/20	
NAME OF PI	JAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
AVERA BO	ORMANN MANOR				NORTH 4TH STREET RKSTON, SD 57366		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CO	(X5) MPLETIC DATE
F 600	Continued From page care. *There was no docun	e 4 nented restorative nursing	F	600			
	care training for RAF *A RA job description administrator A and w of the survey period. -She thought RAF ha	: was requested from vas not provided by the end ad not signed a RA job					
	description, as she had started her employment as a CNA. *Thought RA F had RA training during her previous employment with a sister facility. -There was no documentation to support that the training had occurred.						
	Interview on 1/30/24 a administrator A and c (CCC) E regarding th revealed: *RA F was also a CN	linical care coordinator e use of warm packs				a.	
	*RA F was not provid restorative nursing ca -She previously work	ed initial training in ne as:					
	*CCC E stated nurses was using warm pack she was not certain. *Administrator A state	s may have known RA F s for resident 20's neck but of the process for warm				2	
-	on cognitively impaire	iluded not using warm packs ed residents. ng employees regarding the					
	DON B was not availa the survey period.	able for an interview during	2		3		
	Review of the provide assessment revealed	er's September 2023 facility				Inuation sheet Pag	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES				1	0.0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 43A137		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. 1		ONSTRUCTION	COM	E SURVEY PLETED
		43A137	B. WING			C 01/30/202	
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
AVERA BO	ORMANN MANOR				NORTH 4TH STREET RKSTON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefi Tag		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETIO DATE
F 600	*Staff competency w annually. Review of the provid Restorative Nursing revealed: *"The Restorative Nic coordinated by the D provides exercises for individualized needs evaluates and desig each patient. The pa- by the physical thera exercise program." Review of the provid policy revealed: *"Warm Packs -Moisten wash cloth from the faucet. Write microwave no more in a plastic bag and affected area. Check reheat/reapply as ne cloth/towel in microw Check area where 15-30 [minutes]." -"This policy was de delivery of health se define the standard *The policy did not in warm packs to resid Review of the provid Abuse, Neglect, Mis	uled for five days per week. ras to have been assessed er's November 2023 Care Program policy ursing Care Program, Director of Physical Therapy, or patients based on their . A physical therapist ns the exercise program for titent care staff is instructed aplst on how to carry out that er's undated Warm Packs or towel with warm water ng cloth or towel out, place in than 30 seconds, then place warp with a dry cloth. Apply to c every 15-30 minutes and eeded. Do NOT place wet vave more than 30 seconds warm pack is applied every veloped as a guide for the rvices and is not intended to of care." nclude who was able to apply ents.	,	500	JERGENOT)		
	Abuse, Neglect, Mis	treatment and Resident Property policy				ontinuation shi	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		101/07					C
		43A137	B, WING			01/	30/2024
	ROVIDER OR SUPPLIER			501 NOR	ADDRESS, CITY, STATE, ZIP CODE RTH 4TH STREET TON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
SS=D	-"f. Neglect is the fallu employees or service and services to a resi- avoid physical harm, p emotional distress." *"Abuse policy" -"Additionally, residen abuse, neglect, and h at the facility." -"The facility will strive applicable individuals parties." Services Provided Me CFR(s): 483.21(b)(3)(§483.21(b)(3) Compre- The services provided as outlined by the com- must- (i) Meet professional s This REQUIREMENT by: Based on a review of Department of Health interview, and policy r ensure one of one sam provided appropriate of one of one sampled re pack. 1. Review of the SD D the following: *On 1/20/24 restorativ pack on the back of re -The warm pack was a	re of the facility, its providers to provide goods dent that are necessary to pain, mental anguish, or ts will be protected from arm while they are residing to educate staff and other in techniques to protect all et Professional Standards i) thensive Care Plans or arranged by the facility, prehensive care plan, dor arranged by the facility, prehensive care plan, tandards of quality. is not met as evidenced the South Dakota (SD DOH) online report, eview, the provider failed to mpled restorative alde (F) care to prevent a burn on asident (20) from a warm OH online report revealed e aide F applied a warm sident 20's neck. a heated wet hand towel posable waterproof under		1/2 pr w cc 2. Th the wa pr an tra 3. Re ap co F I	estorative aide F was notified or 24/24 to discontinue use of any acks on resident 20 and on all re ho are cognitively incapable of ommunicating needs. The policy and procedure for head erapy has been changed to refle arm blanket/towel use. This poli- rocedure will be followed by nur- ind restorative nursing care staff. Insing and restorative care staff. State on the new policy by 2/21/ estorative aide F has been educ oply blankets or towels warmed in mmercial warmer (set to 130 de per manufacturer guidelines for evention) to residents requesting oplication.	warm esidents icy and sing All will be 24. ated to in the grees injury g heat	2/21/24
	i						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		MEDICAID SERVICES					. 0938-03
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		43A137	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	01/30/2	
NAME OF P	JAME OF PROVIDER OR SUPPLIER				NORTH 4TH STREET		
AVERA B	ORMANN MANOR				ARKSTON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFL TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE.	(X5) Completk Date
F 658	aide (RA) F regardin report revealed: *She had started pla residents' necks befor restorative nursing c muscles. -She had no training -She had no guidand therapist in the use of Interview on 1/30/24 with registered nurse *CNAs and RA F wei residents who were of tell them if the warm *She was not certain CNAs and RAs in the Interview on 1/30/24 regarding the use of revealed: *Warm packs were of were cognitively awa packs were "too warn *She was not certain RAs in the use of war Interview on 1/30/24 administrator A regar and restorative nursi *There was not a ress program for staff. -CNAs were trained, course, and how to of care.	at 10:44 a.m. with restorative g the above-referenced cing warm packs on ore completing their are to help loosen the neck in the use of warm packs. the from a nurse or physical of warm packs. at 12:45 p.m. of resident 20 e (RN) D revealed: re able to use warm packs on cognitively aware and could pack was too hot. Who would have trained to use of warm packs. at 12:56 p.m. with RN C warm packs for residents and could say if the warm m". who had trained CNAs and rm packs. at 1:06 p.m. with ding the use of warm packs ng care revealed: torative nursing care training during their CNA certification complete basic restorative mented restorative nursing 5.	F	358	 To ensure the new policy/procedure is for residents who have current orders packs/heat thearapy, the DON or desl audit/observe heat therapy application restorative aide F. Each application of therapy will be audited daily X 7 days, of the audit will be reviewed at the 2/2 quality assurance meeting. The comm determine if further auditing is needed A physicians order will be obtained for residents using a warm towel will be add admission orders for all future residen charge nurse may assess a resident far may direct the other nursing or restors staff to apply a warm towel for that res- audit will be completed by the DON or to assure all residents currently using towels have a physician's order. The this audit will be reviewed at the QA m scheduled on 2/20/24. The charge nurses will be responsible checking and logging the temperature towel warmer once each shift. These be audited daily X 7 days, weekly X 1 monthly X 3 months. Auditing will be the DON or designee. The results of it weeks audit will be presented to the Q committee on 2/20/24. The weekly au be presented during the March QA me and the monthly audits will be present the April, May, and June QA meetings 	gnee will by fheat Results 0/24 all er for PRN led to our ts. The or pain and tive care ident. An designee warm results of leeting for of the temps. will month and jone by he first A diting will wetho	

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Event ID: 0F0711

Facility ID: 0068

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		43A137	B. WING			01/30/2024
NAME OF P	ME OF PROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	
AVERA B	ORMANN MANOR				N NORTH 4TH STREET ARKSTON, SD 57366	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLET
F 658	administrator A and w of the survey period. -She thought RA F had description, as she had as a CNA. *Thought RA F had R previous employment -There was no docum training had occurred. Interview on 1/30/24 a administrator A and cl (CCC) E regarding the revealed: *RA F was a CNA. *RA F was not provide restorative nursing ca -She previously worke	as not provided by the end ad not signed a RA job ad started her employment A training during her with a sister facility. hentation to support that the at 3:25 p.m. with inical care coordinator a use of warm packs ed initial training in re as:	F	658		
	the survey period. Review of the provide assessment revealed:	ble for an interview during r's September 2023 facility s to have been assessed				
	annually. Review of the provider's November 2023 Restorative Nursing Care Program policy revealed: *"The Restorative Nursing Care Program, coordinated by the Director of Physical Therapy, provides exercises for patients based on their individualized needs. A physical therapist evaluates and designs the exercise program for each patient. The patient care staff is instructed by the physical therapist on how to carry out that					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					and a second	с	
		43A137	B. WING			01/	30/2024
	Rovider or Supplier Drmann Manor			ŧ	STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) Completion Date
F 658	exercise program." Review of the provide policy revealed: *"Warm Packs -Moisten wash cloth of from the faucet. Wring microwave no more the in a plastic bag and we affected area. Check reheat/reapply as need cloth/towel in microware secondsCheck area applied every 15-30 [I -"This policy was develow delivery of health served delivery of health served delivery of health served delivery of health served training that was reque them those warm pact training that was reque them those warm pact revealed: *"Definitions of Abuse -"f. Neglect is the failu employees or service and services to a resi avoid physical harm, emotional distress." *"Abuse policy" -"The facility will strive	er's undated Warm Packs or towel with warm water g cloth or towel out, place in han 30 seconds, then place varp with a dry cloth. Apply to every 15-30 minutes and eded. Do NOT place wet ave more than 30 a where warm pack is minutes]." eloped as a guide for the vices and is not intended to f care." clude who was able to ks to residents or any hired before to administering eks. er's revised August 2020 eatment and esident Property policy	F	658			

FORM CMS-2587(02-99) Previous Versions Obsolete

Event ID: 0F0711

Facility ID: 0068

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