STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BORMANN MANOR	501 NORTH 4TH STREET , PARKSTON, South Dakota, 57366

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 9/22/26 through 9/24/26. Avera Bormann Manor was found not in compliance with the following requirements: F756 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/22/26 through 9/24/26. Areas surveyed included resident elopements and quality of care related to a resident who had fallen from a sit-to-stand lift. Avera Bormann Manor was found in compliance.	F0000		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the	F0756	1) Resident 2's MRRs for September was reviewed with provider on 9/30/26 and dose reduction completed. Physician's assessment determined the GDR was appropriate and recommended dose reduction. Resident's family was notified of the dose reduction and agreed with plan of care. 2) An audit for all resident MRRs for the month of September was conducted on 10/7/26 with provider recommendations and pharmacy follow through noted on every resident. All residents (49) were reviewed with no other findings of deficient practice, therefore no other residents were affected by the deficient practice. Additionally, no staff were affected by the deficient practice. Following the audit, all residents were assessed with no change of condition noted, protected by ensuring all audits were completed and monitored through the continued audit process. 3) The Medication Regimen Review policy was reviewed in collaboration with Administrator, DON, CQM, and Medical Director on 10/8/26. Education provided on 10/12/26 to all relevant staff (DON, Medical Director, CQM, Pharmacist, and all attending providers) on the MRR Policy. 4) An audit for fifteen (15) residents will be conducted monthly for three (3) months by DON/designee to ensure that communication for pharmacist recommendations is being completed. Data will be brought to QAPI committee monthly by DON. Recommendations for further audits will be made by the QAPI committee thereafter.	10/12/26

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
Lindsay Weber	CEO	10/15/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BORMANN MANOR	**501 NORTH 4TH STREET , PARKSTON, South Dakota, 57366**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0756 SS = D	Continued from page 1 pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure that medication regimen review (MRR) pharmacy recommendations were reviewed and completed by the physician, and that one of one pharmacy consultant (D) ensured pending MRR recommendations were completed with a physician response for one of three sampled residents (2) who were prescribed psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications. Finding include: 1. Review of resident 2’s electronic medical record (EMR) revealed she admitted to the facility on 3/8/21. Her diagnoses included dementia in Alzheimer’s disease (a group of symptoms affecting memory, thinking, and social abilities), anxiety (anticipation of future changes or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and major depressive disorder (a serious, common, and treatable mental health condition characterized by persistent, intense sadness or a loss of interest in activities). Her 9/15/26 Confusion Assessment Method (a standardized tool used by healthcare providers to detect and identify delirium or CAM), indicated there was no evidence of an acute change in mental status from the resident’s baseline, and symptoms of inattention, disorganized thinking, and altered level of consciousness were not present. Resident 2 had a 5/30/26 physician's order for	F0756		

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F0756 SS = D	Continued from page 2 amitriptyline (an antidepressant medication) 25 milligrams (mg) to be administered once a day with evening meal. A 5/30/26 physician's order for clonazepam (an antianxiety medication) 0.25 mg to be administered three times a day with meals. A 5/30/26 physician's order for quetiapine (an antipsychotic medication) 12.5 mg to be administered every evening with a meal. A 5/30/26 physician's order for sertraline (an antidepressant medication) 150 mg to be administered once a day. Resident 2's 2/24/26 monthly MRR completed by pharmacy consultant D indicated that a recommendation was made to “Please assess if a dose reduction is appropriate -OR- if contraindicated, provide clinical rationale below…” regarding her use of amitriptyline, clonazepam, quetiapine, and sertraline. The “No” was circled on the form, and the rationale provided read, “Patient being managed by psychiatry.” The “disagree” box was checked and signed by the physician on 3/16/26. There was no clinical rationale documented in residents 2’s EMR by her physician or psychiatry services. Her 3/23/26, 5/26/26, and 7/29/26 MRRs completed by pharmacy consultant D revealed each review included the recommendation, “Please assess if a dose reduction is appropriate -OR- if contraindicated, provide clinical rationale below…” for the resident's use of amitriptyline, clonazepam, quetiapine, and sertraline. Those MRRs did not have a physician’s signature or a physician's response regarding if a dose reduction of resident 2’s amitriptyline, clonazepam, quetiapine, or sertraline medication should be attempted or if a dose reduction was contraindicated. Her 4/28/26 MRR completed by pharmacy consultant D revealed the pharmacist documented, “No recommendation.” Her 6/23/26 MRR completed by pharmacy consultant D regarding her amitriptyline, clonazepam, quetiapine, and sertraline medications indicated the physician circled the word “yes” and wrote “Not under my care-per PCP [primary care provider]” was hand-written on the MRR. The physician checked the “Agree” box, and signed, and dated the form on 7/28/26. There was no documentation in resident 2’s EMR that indicated any medications were changed following this recommendation. Her 8/27/26 MMR completed by pharmacy consultant D indicated that “[Resident 2] had a GDR [gradual dose reduction] last month that was agreed	F0756		

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F0756 SS = D	Continued from page 3 upon by [the physician], but there were not specifics provided on which medication to reduce. Could this be clarified and updated when possible." No documentation in resident 2's EMR indicated that the physician completed that review or provided clarification regarding the recommended dose reduction. 2. Interview on 9/24/26 at 12:14 p.m. with director of nursing (DON) B regarding the facility's current process for completing the resident's monthly MRRs revealed that pharmacy consultant D was responsible for ensuring the residents' MRRs were completed. DON B received the resident's MRR by email from pharmacy consultant D, printed them, and gave them to clinical quality manager (CQM) E who was responsible for delivering them to the residents' physicians for review. Once the physicians completed their review of the residents' MRRs, they were returned to DON B. DON B would enter any new orders or physician recommendations into the resident's charts. 3. Interview on 9/24/26 at 1:00 p.m. with pharmacy consultant D revealed that he completed the residents' MRRs at the facility once a month. He sent the completed MMRs by email to the facility and included DON B. He stated it was the facility's responsibility to ensure the MRRs were delivered to the physicians for review. Each month he would follow up on any MRR that was not addressed by the physician, and he would coordinate with the nursing staff to contact the physician if needed. He did not contact the physicians directly. He acknowledged that resident 2 had several repeated recommendations that were not addressed by her physician. 4. Interview on 9/24/26 at 3:45 p.m. with CQM E revealed that she worked at the clinic where the resident's physicians worked. When she received the resident's MRRs from DON B, CQM E created a list of what needed to be completed, delivered the MRR's to the physicians, and then she retrieved them from the physicians when they were completed. CQM E stated she did not review the MRR's, she just made sure they are signed by the physicians. She used a list to ensure all resident MRRs were completed and returned to her by the physicians and then she returned the resident's MRRs to DON B. 5. Review of the provider's April 2026 Pharmacy Consultant Expectations policy revealed, "The pharmacy consultant will review antibiotic and psychotropic medication utilization and collaborate	F0756		

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F0756 SS = D	Continued from page 4 on the development of an action plan consistent with best practices and regulatory requirements."	F0756	1) RA III was re-educated on 10/6/26 by Administrator on proper hand hygiene and correct doffing (removal) of PPE. 2) The DON completed a review 10/14/26 of all residents to identify any potential adverse outcomes associated with deficient hand hygiene practice. The review included assessment of current resident condition and changes in condition. Based on this review, no adverse resident outcomes were identified and no infections were noted as being associated with deficient practice. Following the audit, all residents were assessed and protected by following correct hand hygiene practices. 3)The facility completed a review (10/14/26) of the current resident census to identify residents potentially affected. Each resident was reviewed for the presence of wounds, indwelling medical devices, and known MRDO infection or colonization to determine whether EBPs were indicated. Residents identified as requiring EBP were reviewed to verify that appropriate precautions were in place. Residents identified as potentially affected were assessed for signs and symptoms of infection or other adverse outcomes related to the deficient process. No other infections or adverse outcomes were noted. Following the audit, all residents were protected by following correct EBP practices. 4)The Transmission Based Precautions and Enhanced barrier Precautions policy was reviewed by Administrator, DON, and IP Nurse on 10/7/26. Education to all staff will be provided on 10/14/26 by Administrator on Transmission Base Precautions and Enhanced Barrier Precautions, hand hygiene, and donning (applying) and doffing (removal) of PPE. 5)An audit for the completion of hand hygiene will be one twice (2) weekly for four (4) weeks, then twice (2) monthly for two (2) months by DON/designee. Data will be brought to QAPI committee meeting by DON. Recommendations for further audits will be made by the QAPI committee thereafter. 6)An audit for enhanced barrier precautions will be performed twice (2) weekly for four (4) weeks, then twice (2) monthly for (2) months by DON/Designee. Data will be brough to QAPI committee meeting by DON. Recommendations for further audits will be made by the QAPI committee thereafter.	10/14/26
F0880 SS = D	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 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	F0880		

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F0880 SS = D	Continued from page 5 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: Based on observation, interview, record review, and policy review, the provider failed to ensure the staff followed infection prevention and control practices regarding hand hygiene (washing hands with soap and water or using alcohol-based hand sanitizer) and personal protective equipment (specialized gear or clothing worn to minimize exposure to hazards that cause serious workplace injuries, illnesses, or infections, or PPE) use by one of one observed resident assistant III (RA III) (G) after assisting one of one sampled resident (8) who was on Enhanced Barrier Precautions (glove and gown use during contact care, or EBP) to transfer from the resident’s bed to her wheelchair. Findings include: 1. Observation on 9/23/26 at 2:17 p.m. in resident 8’s room revealed RA III G and certified nursing assistant (CNA) F entered resident 8's room to assist her to transfer from her bed to her wheelchair. There was an EBP sign posted on the resident’s door. Both RA III G and CNA F completed hand hygiene, put on a yellow reusable/washable barrier gown, and then put on a pair of gloves.	F0880		

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F0880 SS = D	Continued from page 6 RA III G assisted resident 8 with colostomy (a waterproof external pouch used to collect body waste created from the colon through the abdominal wall) care, removed her gloves, discarded those gloves in the trash can, and put on a new pair of gloves without completing hand hygiene. CNA F remained in the resident's room and wore the same gloves and gown. RA III G and CNA F then assisted resident 8 from her bed to her wheelchair using a total body lift (a mechanical lift and sling used to lift a person's full body). RA III G and CNA F then removed their gowns, rolled them into a bundle and held them in their hands. CNA F handed her bundled gown to RA III G, who held both bundled gowns in her gloved left hand. She removed the glove from her right hand and exited the room with both yellow gowns in her same gloved left hand. RA III G walked through the hallway to the soiled utility room, opened the soiled utility room door with her ungloved right hand, disposed of the gowns from her left hand into a laundry bin, removed the soiled glove from her left hand, and discarded the soiled glove into the trash can. She washed her hands with soap and water in the hallway sink that was located next to the soiled utility room. 2. Interview on 9/23/26 at 2:35 p.m. with RA III G revealed she knew she should have completed hand hygiene after removing her soiled gloves and before putting on a new pair of gloves. RA III G stated that there was no designated location inside the resident's room for the staff to place used gowns, which was why she carried the gowns through the hallway and placed them in the laundry bin located inside the soiled utility room. 3. Review of residents 8's electronic medical record (EMR) revealed she admitted to the facility on 7/10/25 with diagnoses including diverticulitis (the inflammation or infection of small pouches that form in the wall of the colon) of the colon and the presence of a foley catheter (an indwelling tube inserted into the bladder to drain urine). Her EMR revealed, "Isolation: Enhanced Barrier Precautions (nursing home use only)." 4. Interview on 9/24/26 at 11:44 a.m. with registered nurse (RN)/infection preventionist (IP) C revealed she expected the staff to perform hand hygiene after removing soiled gloves, before putting on a new pair of gloves, and before they exited all resident's rooms. She stated that soiled linen barrels were placed in the hallway outside resident rooms who	F0880		

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F0880 SS = D	Continued from page 7 were on EBP, but she acknowledged that this was not done consistently. RN/IP C expected the staff to not walk in the hallway with one soiled gloved hand holding used gowns and to not use their unclean hands to open the soiled utility door. 5. Interview on 9/24/26 at 12:14 p.m. with director of nursing B (DON) revealed she expected the staff to remove their gowns and gloves before they exited a resident's room and to not carry soiled gowns uncovered in the hallway. She expected the staff to perform hand hygiene immediately after removing PPE. DON B agreed that if the staff walked through the hallway with one soiled gloved hand, opened the door to the dirty utility room with unclean hands, and carried soiled gowns in the hallway, these actions could increase the risk of spreading infections to the residents. 6. Review of the provider's April 2026 Policy on Transmission Based Precautions and Enhanced Barrier Precautions revealed "Remove PPE appropriately and complete hand hygiene before leaving the room," and "Hand hygiene [should be completed] upon entering and leaving the room and after removal of PPE."	F0880		

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	43A137	A. BUILDING **01 - MAIN BUILD...** B. WING	**09/24/2026**

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/24/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Avera Bormann Manor was found in compliance.	K0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rhonda Wilson	CEO	10/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 9/24/26. Avera Bormann Manor was found in compliance.	E0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tmeray Wilson	CEO	10/12/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10660	A. BUILDING: _____ B. WING _____	09/24/2026

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/22/26 through 9/24/26. Avera Bormann Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Lindsay Wilson — CEO — 10/12/2026