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 02/04/2026

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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/2/26 through 2/4/26. Areas surveyed included patient neglect, quality of care/treatment, nursing services, and unqualified staff. Avera Bormann Manor was found not in compliance with the following requirements: F550, F554, F658 and F689.	F0000		
F0550 SS = E	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.	F0550	Resident 6,8, & 9 will be served meals in the dining room in the order that they arrive or based on table rotation. Resident 1 has requested an apple with each noon meal; it was added to her care plan and diet card. Residents 1, 2, 3, & 4 will not have negative outcomes related to call light wait times. All staff will be educated to the Avera Care Standards, which covers Communication (verbal & non-verbal), Attitude, Responsiveness, and Engagement; education will be led by Administrator on 2/26/26. This education will ensure other residents' rights are honored. A CARE standards audit will be completed on three (3) residents one (1) time weekly for three (3) months by Administrator/Designee. Audit will include meal observations & call light audits. Data will be brought to QAPI monthly by Administrator/Designee. Recommendations for further studies will be made by the QAPI Committee.	3/5/26

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
Kimberly Ramey	LTC Administrator	2/25/2026

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 02/04/2026

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F0550 SS = E	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 South Dakota Department of Health (SD DOH) complaint the review of observations, interviews, electronic medication records and policy review revealed the facility failed to allow resident their right of self-determination. * 3 of 36 residents were not allowed to eat until the end of the meal service per a nurses request (6,8,9). * 1 additional food request was not granted * Call light times were reviewed due to excess wait times. 4 of 11 residents (1,2,3,4) had negative outcomes from wait times. Findings include: 1. Review of the12/2/2025 SD DOH complaint intake revealed: *Medications were given in the dining room. *Staff were available to assist residents to eat each meal. *Blood sugars were being taken at appropriate time and locations as per resident doctors' orders and care plan preferences. *Unwitnessed and unreported falls. *Licensed staff were working in the facility within their scope of practice. *Hygiene with nails, hair, bathing and shaving were completed. 2. Observation on 2/3/26 at 7:50 a.m. in the dining room during the breakfast meal service revealed that	F0550		

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F0550 SS = E	Continued from page 2 residents (6,8, and 9) were seated at 7:30 a.m., before other residents arrived in the dining room, but were the last to be served their meals. 3. Interview on 2/3/26 at 8:00 a.m. with certified nursing assistant (CNA) M revealed residents 6, 8 and 9 are usually served last. 4. Interview with on 2/3/26 at 8:25 a.m. with food service worker (FSW) P revealed that as residents entered the dining room, the dining staff pulled the resident's diet card and placed it on the bottom of the pile of resident diet cards to serve the residents in order. They would serve one table at a time if all the residents were there. FSW P stated the nursing staff requested that residents 6,8 and 9 were to be served last due to resident 6 having a high risk for falling. 5. Observation on 2/3/26 at 11:15 a.m. in the dining room revealed residents (6,8, and 9) were seated and waiting for their lunch meals to be served. 6. Interview on 2/3/26 at 11:30 a.m. with registered nurse (RN) F revealed she asked the dietary staff to serve resident 6 last because she had a high risk of falling. 7. Interview on 2/3/26 at 11:33 a.m. with RN E revealed she was not aware of an issue or a previous request to serve resident 6 last, and she did not request residents to be served last. 8. Observation on 2/3/26 at 11:34 a.m. revealed that residents 6, 8 and 9 were served their lunch meals after waiting at the table for about 19 minutes while other residents ate. 9. Observation on 2/3/26 at 11:56 a.m. revealed that resident 7 requested an apple cut up and put into a small bowl. Cook Q replied to the request with ok, when the meal service is done. 10. Observation on 2/3/26 at 11:58 a.m. revealed that the lunch meal service was completed. 11. Interview on 2/3/26 at 12:16 pm. with cook Q revealed the health facilities surveyor requested the apple again for resident 7 and cook Q said "okay." 12. Observation on 2/3/26 at 12:19 pm. revealed Cook Q delivered the apple by sliding the bowl in front of resident 7 who replied, "thank you" and cook Q walked away without acknowledging resident 7.	F0550		

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F0550 SS = E	Continued from page 3 13. Interview on 2/3/26 at 1:40 p.m. with director of food services (DFS) R revealed residents were to be served meals when they arrived in the dining room and were seated at their table. DFS R was informed on 2/3/26 that residents 6, 8 and 9 were to be served last due to a nursing request. She expected the residents to be served their meal when they came into the dining room for that meal service. DFS R expected any additional food requests from the residents would be addressed immediately following the meal service. 14. Interview on 2/3/26 at 8:50 a.m. with resident 3 revealed that she had to sit soiled after a bowel movement for one to two hours before she could get help. She used her pendant (small, portable, wireless, device used in healthcare settings to allow individuals to immediately request assistance) or call light to alert staff when she needed assistance. A staff member would come and turn it off and say “we will be back in a few minutes” but they did not always come back. 15. Review of the call light log report from 1/9/26 through 1/24/26 revealed four of the eleven residents reviewed (1,2,3, and 4) had call light response times greater than 25 minutes. *Resident 4’s call light response times revealed: - On 1/17/26 at 6:32 p.m. his call light was on for 34 minutes and 28 seconds. - On 1/23/26 at 7:12 p.m. his call light was on for 25 minutes and 4 seconds. * Resident 3’s call light response times revealed: -On 1/10/26 at 6:46 p.m. her call light was on for 29 minutes and 33 seconds. -On 1/11/26 at 7:13 p.m. her call light was on for 35 minutes and 42 seconds. -On 1/12/26 at 6:09 p.m. her call light was on for 49 minutes and 16 seconds. -On 1/13/26 at 12:19 p.m. her call light was on for 25 minutes and 37 seconds. -On 1/15/26 at 7:34 p.m. her call light was on for 25 minutes and 34 seconds. -On 1/17/26 at 5: 56 p.m. her call light was on for 34	F0550		

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F0550 SS = E	Continued from page 4 minutes and 2 seconds. -On 1/21/26 at 6:54 p.m. her call light was on for 29 minutes and 1 second. -On 1/23/26 at 7:02 p.m. her call light was on for 26 minutes and 5 seconds. 16. Interview on 2/4/26 at 8:55 a.m. with resident 4 revealed: * Resident 4 felt like he waited for a long time before a staff member answered his call light. * He urinated on himself while he waited for staff to come and assist him to the bathroom. * He felt disgusted not being able to get the help he needed to use the bathroom before he urinated on himself. 17. Interview on 2/4/26 at 9:15 a.m. with resident 3 revealed: * Resident 3 felt like she waited a long time for her call light to be answered. * She sat in her bowel movements while she waited for staff to come and assist her to the bathroom, which caused her buttocks to be red and have a rash. * She felt like there was nothing she could do about the long wait time for staff to come and help her. She felt forgotten by the staff. 18. Resident 2's call light response times revealed: -On 1/9/26 at 5:51 a.m. his call light response time was 47 minutes. -On 1/10/26 at 7:16 a.m. his call light response time was 35 minutes. -On 1/11/26 at 6:55 a.m. his call light response time was 40 minutes. -On 1/11/26 at 5:41 p.m. his call light response time was 50 minutes. -On 1/12/26 at 6:12 a.m. his call light response time was 35 minutes.	F0550		

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F0550 SS = E	Continued from page 5 -On 1/15/26 at 7:56 a.m. his call light response time was 31 minutes. -On 1/20/26 at 7:34 p.m. his call light response time was 28 minutes. -On 1/22/26 at 12:34 p.m. his call light response time was 28 minutes. 19. Interview on 2/4/26 at 9:22 a.m. with resident 2 revealed: *He waited for his call light to be answered “often.” *When he had to use his bathroom, he was incontinent (involuntary urine or bowel leakage) before staff arrived to help him. *He asked the staff why it took them to help him, and they told him they were helping other residents. *He has yelled from his doorway to get staff to come to his room to help him when his call light was on for over 30 minutes. *He stated, “It’s embarrassing to have to yell in the hallway for help.” 20. Resident 1’s call light response times revealed: -On 1/11/26 at 11:01 a.m. his call light response time was 27 minutes. -On 1/15/26 at 12:20 p.m. his call light response time was 26 minutes. -On 1/16/26 at 7:43 a.m. his call light response time was 25 minutes. -On 1/20/26 at 7:20 a.m. his call light response time was 27 minutes. -On 1/23/26 at 11:38 a.m. his call light response time was 25 minutes. 21. Interview on 2/4/26 at 9:47 a.m. with resident 1 revealed: *He turned his call light on when he wanted to get up for meals.	F0550		

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F0550 SS = E	Continued from page 6 *He waited 20 to 30 minutes for the staff to come in and get him up. *On 2/3/26 the staff left him in his room at suppertime until they got everyone out of the dining room before they helped him up for his meal. *It frustrated him when that happened, which was for the it happens around noon and evening meal services. 22. Interview on 2/4/26 at 9:25 a.m. with certified nursing assistant (CNA) K revealed her expectation of a call light response time was one to five minutes. 23. Interview on 2/4/26 at 9:30 a.m. with CNA M revealed her expectation of a call light response time was five to ten minutes. 24. Interview on 2/4/26 at 10:25 a.m. with CNA I revealed her expectation of a call light response time was at most five minutes. 25. Interview on 2/4/26 at 10:33 a.m. with CNA L revealed her expectation of a call light response time was two minutes. 26. Interview on 2/4/26 at 1:30 p.m. with director of nursing (DON) B revealed: *Her expectation of a call light response time was nothing over 20 minutes. *Call light audits were being completed once or twice monthly. *Nothing had been done with the audits that had been completed. 27. Review of the providers revised 2/2025 Call Light policy revealed: * “Objective 1. To respond to patient/resident’s request and needs on a timely basis.” * “Procedure 2. Answer light promptly.”	F0550		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp	F0554		

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F0554 SS = D	Continued from page 7 CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint report review, observations, interviews, and policy review, the provider failed to ensure physician orders were received for self-administration of medications for two of seven observed sampled residents (2 and 3) who self-administered medications. Findings Include: 1. Review of the12/2/2025 SD DOH complaint intake revealed: *Medications were given in the dining room. *Staff were available to assist residents to eat each meal. *Blood sugars were being taken at appropriate time and locations as per resident doctors' orders and care plan preferences. *Unwitnessed and unreported falls. *Licensed staff were working in the facility within their scope of practice. *Hygiene with nails, hair, bathing and shaving were completed. 2. Observation on 2/3/26 at 8:20 a.m. revealed registered nurse (RN) E left resident 2's cup of medications containing 14 pills with him at the breakfast table. Resident 2 then dropped a yellow pill onto the floor and told a DOH surveyor, who then alerted RN E. 3. Observation on 2/4/26 at 7:55 a.m. in the dining room revealed registered nurse (RN) F left resident 3's cup of medications containing seven pills with her at the breakfast table.	F0554	Resident 2 & Resident 3 have a completed self administration assessment and physician's order was obtained for resident 2 & 3 to self-consume medications after set-up. All residents were audited to ensure if they are self administering medications that there was self administration assessment & physician's orders. All staff responsible for medication administration will be re-educated by Director of Nursing/Designee on 2/26/26 to the self administration policy and where to confirm that both the self administration assessment and physician's order is in place. A Self Administration Medication Audit will be conducted weekly for three (3) residents by the Director of Nursing/Designee. Data collected will be brought to QAPI by the Director of Nursing/Designee monthly. Recommendations for further studies will be made by the QAPI committee.	3/5/26

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F0554 SS = D	Continued from page 8 4. Observation on 2/4/26 at 8:00 a.m. revealed registered nurse (RN) G left resident 2's cup of medications containing twelve pills with him at the breakfast table. 5. Observation on 2/4/26 at 8:07 a.m. revealed RN G left the dining room and resident 2 had yet to take his medications. 6. Interview and electronic medical record (EMR) review on 2/4/26 at 8:12 a.m. with RN F revealed resident 2 had a medication self-administration assessment completed on 12/10/25. 7. Observation on 2/4/26 at 8:30 a.m. in the dining room revealed: *RN G asked resident 2 if he wanted his MiraLAX, and instructed him that if he did not, to leave it on the table. RN G reminded resident 2 to take his medications. *At 8:37 a.m. resident 2 left the table to change the television (TV) channel and then returned to his table at 8:39 a.m. *Resident 3's medications were gone from her medicine cup at 8:37 a.m. *Resident 2 took his medications at 8:47 a.m. 8. Interview and observation with RN G on 2/4/26 at 10:55 a.m. revealed: * RN G reviewed resident 2 and 3's medication administration record (MAR) within their EMR and did not find a physician's order for self-administration of their medications. 9. Review of resident 2's EMR revealed he had a 8/19/25 physician's order to self-administer Kenalog paste for oral sores. 10.Review of resident 3's EMR revealed she had a 12/17/24 physician's order to self-administer/self-consume her nebulizer treatment after a nurse or medication aide it up for her.	F0554		

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F0554 SS = D	Continued from page 9 11. Interview on 2/4/26 at 12:59 p.m. with RN E revealed: *She reviewed the residents' MAR which indicated if a medication could be self-administered by that resident. 12. Interview on 2/4/26 at 1:30 p.m. with director of nursing (DON) B revealed the medication self-administration assessment was completed first to ensure the resident qualified and then the nursing staff worked with the registered nurse/quality specialist (RN/QS) D to get the physician's order. 13. Interview on 2/4/26 at 2:18 pm with RN/QS D revealed she completed random resident chart audits, and if she identified a resident who may benefit and wanted to self-administer their medications, she would discuss that with the nursing team. The nursing team or herself obtained the physician's order and entered it into their electronic medical record. Any nurse was able to get the orders from the physician. She acknowledged that a resident's medication self-administration order should be checked before leaving the medication with that resident. 14. Review of the provider's revised October 2025 LTC Medication Management -System Standard Policy revealed: * "It is the policy of the facility to maintain a safe and competent medication management system that is based on the best practice and the care process of the residents that includes: recognition of the problem/need, assessment, diagnosis(es), medication administration, management, monitoring and revising the individualized, person-centered approach to care as well as documentation consistent with standards of medication management and administration standards." * J. "Residents may self-administer medications when assessed and determined that the practice is clinically appropriate, and authorized by the attending physician, in accordance with procedures for self-administration of medications." 15. Review of the provider's revised January 2016 Self-Administration of Medications policy revealed: * "Purpose: standardize the approval and practice of	F0554		

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F0554 SS = D	Continued from page 10 allowing resident's to safely self-administer their drugs and medications by the interdisciplinary team." * "Policy Statement: Avera will utilize a centralized, standardized and managed process to assure Self Administration of Medications by residents who desire to do so provided the interdisciplinary team (IDT), including at least a physician, nurse pharmacy and social worker has determined the practice would be safe for the resident and other residents of the facility. Avera policies will be distributed electronically." * "Policy Scope: This policy will apply to all individuals implementing self-administration of medication at Avera LTC Facilities. It is the responsibility of each Director of Nursing to ensure the entities do not have policies that conflict of this policy. Avera entities are required to adopt this Avera LTC Governance Committee policy." * "Policy Implementation: b. If the IDT approves a resident for self-administration of medication the facility will i. obtain physician's order for self-administration of medications after set up and/or for bedside medications. This order will be placed in the Electronic Health Record (EHR) under Self Administration of Medications."	F0554		
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 South Dakota Department of Health (SD DOH) complaint intake review, observations, interviews, record review, electronic medication records and policy review, the provider failed to ensure the staff followed professional standards regarding the safe transfer of one of one sampled resident (5) who was transferred with a total body mechanical lift by the certified nursing assistant (CNA) K and registered nurse (RN) F after he fell and had a suspected hip injury. Findings Include:	F0658	A backboard will be used for residents ~~for residents~~ who may have a suspected spinal or limb injury. Stretcher straps have been ordered to support a backboard transfer from the floor to the transportation cot. A procedure for use of the backboard & ez way stretcher straps was created by Director of Nursing on 2/25/28. All nurses were educated to this procedure on 2/26/28 by the Director of Nursing/Designee. An audit of incident reports will be completed weekly by the Director of Nursing/Designee to ensure that proper transfer techniques were used for any resident with suspected spinal or limb injuries. Data collected will be brought to QAPI monthly by the Director of Nursing/Designee. Recommendations for further studies will be made by the QAPI committee.	3/5/26

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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
F0658 SS = D	Continued from page 11 1. Review of the12/2/2025 SD DOH complaint intake revealed: *Medications were given in the dining room. *Staff were available to assist residents to eat each meal. *Blood sugars were being taken at appropriate time and locations as per resident doctors' orders and care plan preferences. *Unwitnessed and unreported falls. *Licensed staff were working in the facility within their scope of practice. *Hygiene with nails, hair, bathing and shaving were completed. 2. Interview on 2/3/26 at 9:20 a.m. with registered nurse (RN) F revealed she was at a nursing staff meeting when she heard a noise of someone falling. She then went into resident 5's room and saw him lying on his right side by the door, his walker was beside him, and the bathroom door open. RN F completed range of motion (measurement of movement around a joint or body part) (ROM) exercise with him, completed her nursing assessment (vital signs and pain assessment) of resident 5 and noticed his legs were two different lengths. She requested a medical cart from the emergency department (ED) within the attached hospital to transfer him there. She could not remember how the staff transferred resident 5 to the medical cart. 3. Interview on 2/3/26 at 10:20 a.m. with certified nursing assistant (CNA) K revealed she was assisting a resident back to their room when she saw resident 5 walking alone in his room. She then turned back to sit down the resident she was walking to assist resident 5. By the time she got back to resident 5's room, she heard a noise and saw him on the floor. She stated, "I saw him lying on his right side with the door partially open with the walker in front of him." She did not know how he had gotten back to his room or if someone assisted him there. She called CNA L to bring a total body lift and sling (a mechanical lift and sling used to lift a person's full body) to his room to transfer him off the floor. She stated RN F heard the noise, came into his room, and did his assessments. After the nurse completed his assessment. This included vital signs, ROM, and pain evaluation. She and other staff members placed the total body lift sling under him.	F0658		

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F0658 SS = D	Continued from page 12 Resident 5 was in pain or uncomfortable when they were trying to put the sling under him. The staff changed his incontinence (involuntary urine or bowel leakage) brief as he was incontinent of a bowel movement. 4. Interview on 2/3/26 at 10:35 a.m. with CNA L revealed that she was in the dining room assisting other residents to eat when she heard CNA K ask her to get a total body lift and sling for resident 5 who was on the floor. CNA L retrieved the sling and handed it off to another staff member in resident 5's room and went back to assisting other residents in the dining room. 5. Review of resident 5's electronic medical record (EMR) revealed the documentation regarding his fall on 11/20/25 did not explain how he was transferred from the floor to the medical cart. 6. Interview on 2/4/26 at 10:35 a.m. with RN F revealed that if someone fell and had a notable injury, she would place a pillow under the resident's head to keep them comfortable while she completed their fall assessment. She said it was obvious resident 5's hip was broken, but she does not remember how they transferred him onto the medical cart. She stated "You know the process of what you are going to do based on your assessment at that time. We don't have to call 911 to get residents off the floor and to the ED we just take them. Then family decides if they need treatment." 7. Review of 11/20/25 facility reported incident (FRI) regarding resident 5 revealed "resident complains of right upper leg pain with ROM on right leg. ROM on other three extremities normal. Neuro assessment normal. Resident assisted off the floor onto a medical cart by total lift, three CNAs, and two RNs. During transfer resident complains of right leg pain and is holding right thigh." 8. Interview on 2/4/26 at 10:55 a.m. with RN G revealed the nurse will complete her assessments on the resident who fell while they are on still on the ground. The resident's assessment included, getting a set of vital signs, gathering a total body lift, sling and extra staff to help transfer the resident. If it was a head, neck or hip injury she called the physician before she moved the resident, and then the resident was transported to the ED. 9. Interview on 2/4/26 at 12:33 p.m. with director of physical therapy U revealed that she treated resident 5 for two therapy sessions before he passed away. On 1/11/26 he was in too much pain to go from a lying down	F0658		

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F0658 SS = D	Continued from page 13 to a sitting up position. 10. Interview on 2/4/26 at 12:52 p.m. with DON B revealed that the professional standards of care followed by the facility was the Fundamental and Advanced Nursing Skills Third Edition by author Gaylene Bouska Altman RN. 11. Review of resident 5's physical therapy notes revealed "The patient did not do well trying to transfer from sit to supine in order for therapy to do some manual therapy (MT). He screamed in pain and then laid on his back and would not turn to the side. We ended up sitting him up and the therapist doing manual therapy at the edge of the bed (EOB) sitting." 12. Interview on 2/4/26 at 1:30 p.m. with director of nursing (DON) B revealed that it was the facility's process to lift residents with the total body lift even if the resident had a suspected injury. DON B stated resident 5's fall on 10/31/25 was a fall without injury. On 11/11/25 he was unable to get out of bed and was then sent to the ED where he was diagnosed with an L1 (lumbar one) burst fracture. On 11/13/25 he started physical therapy and his Tramadol (pain medication) 50 milligrams (mg) was increased from twice a day to three times a day. His pain was worse for 3 days and then resident 5 reported he was feeling fine and used his wheelchair as needed. 13. Interview on 2/4/26 at 3:00 p.m. with RN coordinator C revealed that if a resident was identified to have an injury after falling, such as resident 5, she would not use a mechanical total body lift to transfer the resident. She would get a hard backboard (a rigid, flat device used in emergency medical services (EMS) to immobilize and transport patients with suspected spinal or limb injuries) from the ED and ask the ED staff to assist her with immobilizing the area with the suspected injury. RN C said she was an ED nurse and knows where the items are to assist with injuries like resident 5's, but she did not think that most of the staff knew what to do or where to get a back board from. RN C would not have changed a soiled incontinent brief if a resident's hip was suspected to be broken. She would only change a soiled incontinent brief if there were enough staff to immobilize the area to prevent further injury to the resident. She did not know what the facility's policy was on transferring a resident with a hip injury. 14. Review of providers procedural guide Fundamental and Advanced Nursing Skills Third Edition, Skills 2-1 Proper Body Mechanics, Safe Lifting and Transferring	F0658		

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F0658 SS = D	Continued from page 14 Page 152 Special Considerations revealed, “Certain clients with spinal injuries or spinal surgery may require “logrolling,” a technique of moving or turning a client, whereby the body is kept in a protected straight alignment during the transfer.” Author: Gaylene Bouska Altman RN.	F0658	For the safety of all residents including Resident #1, All nursing staff responsible for transfers using the mechanical lifts will have education provided by the Director of Nursing/Designee on 2/26/26. Reminders were mounted on the lifts for staff to pause prior to moving residents to ensure that straps are fully hooked. Mechanical lift transfer audits will be conducted on three (3) residents per week for three (3) months by the Director of Nursing/Designee. Data collected will be brought to QAPI committee meetings monthly by the Director of Nursing/Designee. Recommendations for further studies will be made by the QAPI committee.	3/5/26
F0689 SS = D	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) review, record review, interview, and policy review the provider failed to ensure the safety of one of one sampled resident (1) who fell from a full body mechanical lift (a lift and sling used to lift a person’s body) while being transferred from his bed to his wheelchair by certified nursing assistant (CNA) I and CNA J which required him to go to the emergency room for evaluation. Findings include: 1. Review of the 1/6/26 SD DOH FRI report revealed: *On 1/6/26 at 5:20 p.m. resident 1 was being transferred by CNA I and CNA J from his bed to his wheelchair with a full body mechanical lift CNA H was in training and was observing. *CNA’s I and J and resident 1 reported hearing a snap sound before resident 1 fell out of the full body mechanical lift. *Resident 1’s left leg slipped out of the sling first, followed by his left shoulder, and then the rest of his body. *Resident 1 hit his head but did not lose	F0689		

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F0689 SS = D	Continued from page 15 consciousness. *When director of nursing (DON) B entered the room, the sling was in the air with two shoulder straps and one leg strap attached to the full body mechanical lift. *Resident 1 stated he hit his hip first and complained of his neck hurting. *His vital signs (measurements of the body's basic functions such as temperature, blood pressure, pulse, and respiration rate) were blood pressure 139/106, temperature 97.7, pulse 71, respirations 22 and oxygen saturation (percentage of oxygen in the blood) 99 percent. *The neurological assessment (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) was completed and was noted to be normal by registered nurse (RN) S. *Resident 1 was sent to the emergency department (ED) because he had previous paraplegia (the loss of motor or sensory function in the lower extremities) after a spinal cord injury. *A Computed Tomography (CT) (a medical imaging technique that creates detailed cross-sectional pictures of the body) scan was completed on resident 1's head and neck, which were negative. *X-rays of resident 1's shoulder, hip and pelvis were completed which were negative for any abnormalities. *There were no new orders received. *Resident 1 was to be monitored for any pain changes. *The family was notified of resident 1's fall and transfer to the ED. *The investigation was completed by the provider concluded CNA I and CNA J were involved in the resident's transfer. -CNA I was operating the full body mechanical lift. -CNA J was guiding the resident into his wheelchair. -Resident 1's care plan was followed for his transfer. -A medium sling was used for the full body mechanical lift.	F0689		

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F0689 SS = D	Continued from page 16 -CNA's H, I, and J had completed mechanical lift education and competencies. -The total body mechanical lift and sling were inspected with no issues identified. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted to the facility on 5/10/24. *His 12/17/25 Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated his cognition was intact. *His 12/18/25 Fall Risk Assessment score was 3 which indicated he had fall risk precautions. *His diagnoses were: -traumatic spinal cord dysfunction (causes immediate to progressive dysfunction below the injury site, including paralysis, loss of sensation, loss of bowel and bladder control) and paraplegia. 3. Interview on 2/2/26 at 2:15 p.m. with resident 1 revealed: *On 1/6/26 he was transferred using the full body mechanical lift by CNA I and CNA J. *CNA H was training and stood against the wall. *He was going from the bed to the wheelchair, when he slid out of the sling onto the floor and hit his head and right shoulder on the wheelchair when he landed on the floor. *He thought that a strap was not hooked to the lift and that is how he slid out and fell onto the floor. *He was transferred over to the ED and they completed scans and X-rays to make sure he had no broken bones. *The scan made sure his device to his heart for filtering blood clots did not move because of the fall. *He was unsure if the CNAs were holding onto the sling when they moved him but thought that was how he normally transferred into his wheelchair. *He had no injuries from the fall.	F0689		

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F0689 SS = D	Continued from page 17 *He stated the staff were using the right sling during the transfer. *He was assessed by the nurse for the sling size to use for his full body mechanical lift transfers. 4. Interview on 2/2/26 at 3:13 p.m. with CNA H revealed: *She was observing the transfer of resident 1 on 1/6/26 when he fell out of the full body mechanical lift. *She only observed during the transfer of resident 1. *She stated it looked like the black strap on the sling was not securely hooked and slipped off the full body mechanical lift. *CNA I was operating the lift. *CNA J was holding resident 1's legs and knee while guiding him into his wheelchair. 5. Interview on 2/2/26 at 3:55 p.m. with CNA I revealed: *She has worked for the facility since 9/29/25. *She was operating the lift during resident 1's fall on 1/6/26. *CNA J was guiding the resident into his wheelchair. *The lower sling strap were to cross between the residents legs and then hook on to the bar on the full mechanical lift. *While CNA J got behind the wheelchair to guide resident 1 into his seat, she heard a snap/pop sound. *The lower sling strap from the left side of his body, which was attached to the right side of the full body mechanical lift bar had come off the bar and resident landed on his hip first, then his shoulder, and then hit his head on the floor. *The lower sling strap from the left side of his body was not attached to the bar on the right side of the full body mechanical lift after resident 1 fell, but there were no broken or missing loops to the sling when the staff checked.	F0689		

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F0689 SS = D	Continued from page 18 *Before the transfer she had double checked the straps on the right side of the full body mechanical lift. *CNA J had checked the straps on the left side of the full body mechanical lift before they had transferred resident 1. *She has never had the mechanical lift safety checklist competencies completed for her. 6. Interview on 2/3/26 at 9:55 a.m. with CNA J revealed: *She had assisted in the transfer of resident 1 on 1/6/26 when he fell out of the full body mechanical lift. *She and CNA I were transferring resident 1 from his bed to his wheelchair. *She and CNA I placed the medium sling under resident 1. *Resident 1 used his trapeze (a bar to help reposition or transfer out of bed) to lift himself off the bed while they placed the sling under him. *The sling straps were placed correctly on the full body mechanical lift, crossing the lower straps between his legs before attaching to the lift bars. *She grabbed behind him with the sling and CNA I operated the full body mechanical lift. *When she looked up she saw one of resident 1's legs in the air, and then he was on the floor. *DON B entered the room after he landed on the floor. *Resident 1 liked to adjust himself in the sling once he was in it. *She was unsure how the strap became disconnected from the full body mechanical lift. *She only observed 3 straps for the sling still connected to the full body mechanical lift after resident 1 was on the floor. *Resident 1 hit his back and grabbed his arm when he landed on the floor.	F0689		

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F0689 SS = D	Continued from page 19 *She was unsure if he hit his head. *Resident 1 was sent to the ED for evaluation after the fall. *She always double checks that the sling straps are attached to the lift bar before a resident transfer. *She watched educational videos on the full body mechanical lifts and completed a quiz. *She was unsure if she had the full body mechanical lift safety checklist competencies completed for her. 7. Interview on 2/3/26 at 2:10 p.m. with DON B revealed: *She was in her office next to resident 1's room on 1/6/26 when she heard a crash and swearing. *When she entered resident 1's room, he was on the floor. *Three straps were attached to the full body mechanical lift, one strap on the bottom part of the sling was not attached. *RN S came into resident 1's room to assess him and completed vital signs and a neurological evaluation. *Resident 1 complained of neck pain; RN S obtained a collar for protection. *Resident 1 was placed on a cot and transferred to the ED for evaluation. *RN S notified the family of his fall, and his transfer to the ED. *CNA J stated she hooked one side of the straps to the mechanical lift and CNA I had hooked the other straps to the lift. *DON B checked the sling after the incident occurred, and there were no tears or rips in the sling, she even checked it a second time the following day. *Her assumption is that the strap was not on the inside of the hook on the lift bar. *She has completed visual observations of staff using the total body mechanical lifts to transfer residents, but they were not documented.	F0689		

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F0689 SS = D	Continued from page 20 *She expected staff to double check sling straps before lifting or transferring residents with any mechanical lifts. 8. Interview on 2/3/26 at 7:47 p.m. with RN S revealed: *CNA I and CNA J were the staff that transferred resident 1 on 1/6/26 when he fell from the full body mechanical lift. *She was notified of the fall by DON B. *Resident 1 was on the floor when she entered the room and complained of neck pain. *She notified the ED and placed a collar on resident 1 for protection before transferring him to ED. *She completed vital signs, and neurological [neuro] checks on resident 1. *Resident 1 returned later that evening with no new orders, injuries or fractures from the fall. *Every shift follows-up with neuro checks and pain monitoring and vital signs for 72 hours after a fall a resident fall. 9. Review of the provider's revised 1/26 Mechanical lifts policy revealed: *"The administrator of each facility is accountable for establishing policies, procedures, training and motivation to avoid injuries and prevent loss of property. Each facility shall adopt and communicate safety policies and procedures to all staff. Safety is also a responsibility of every employee. Each employee must be willing to work together to promote a safe and healthy workplace. Everyone on staff must cooperate and communicate so that potential problems can be prevented or corrected. A. All nursing personnel will have annual in-services on the correct procedures for lifting and transferring, including the correct use of gait belts and the use of mechanical lifts."	F0689		