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

PRINTED: 01/31/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		43A137	B. WING _			01/20/2022	
	NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR			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 PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F 00	00			
F 700 SS=E	42 CFR Part 483, Sut Long Term Care facilit 1/19/22 through 1/20/	n survey for compliance with opart B, requirements for ties, was conducted from 22. Avera Bormann Manor pliance with the following	F 70	00 ·			
	a bed or side rail is us correct installation, us						
		the resident for risk of rails prior to installation.					
	bed rails with the resid	the risks and benefits of dent or resident tain informed consent prior					
		that the bed's dimensions e resident's size and weight.					
	and maintaining bed r	I specifications for installing					
	Surveyor: 26632						
	NECTORIO OD DEGUIDESIO	HODI JED DEDDECENTATIVE'S SIGNATI IDI	=	TITI F		(X6) DATE	

Mary Kummer

LTC Administrator

2/13/22

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		43A137	B. WING_		01/20/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 501 NORTH 4TH STREET PARKSTON, SD 57366	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
F 700	Continued From pag	e 1	F 7	700	3/11/22	
	and policy review, th of 37 residents (1, 13 who had side rails or	on, interview, record review, e provider failed to ensure 8 3, 14, 17, 18, 21, 32, and 35) on their beds had been nen applied and on a quarterly de:				
	1 revealed: *She was seated in I *A quarter length sid bed was elevated. Review of resident 1	e rail near the head of the 's medical record revealed	F700-1	A restraint evaluation assessmer completed on resident #1. A physical restraint consent form sent to her daughter that explains of the use of side rails. Addendum: This consent form had to the facility as of 2/12/22	has been s the pros and cons	
	2. Observation on 1/ 18 revealed: *She was laying in b	ts had not been completed. /19/22 at 8:52 a.m. of resident led. le rail near the head of the	F700-2	A restraint evaluation assessment completed on resident #18. A physical restraint consent form her sister that explains the prosecuse of side rails. Addendum: The form has been serturned to the facility.	n has been given to and cons of the	
		8's medical record revealed ts had not been completed.				
	resident 35 had a or bed. The side rail wa the wall. She was se time of the observat		F700-3	The side rail has been taken do Addendum: The rail has been z staff from utilizing them.	own on #35's bed. cip-tied to prevent	
		35's medical record revealed ts had not been completed.				
	two quarter length s	/20/22 at 7:45 a.m. revealed ide rails in the up position on he resident was in bed	F700-	A restraint evaluation assessmer completed on resident #13. He l information on side rails and a co Addendum: Resident #13 has sign	has been given the onsent form to sign.	

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STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		43A137	B. WING		01/20/2022	
NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 700	Continued From page sleeping at this time.	2	F 700	O		
	5. Observation on 1/2 one quarter length sid resident 14's bed. The this time. Review of resident 14'	's medical record revealed had not been completed. 0/22 at 7:46 a.m. revealed e rail in the up position on e resident was not in bed at 's medical record revealed	F700-5	A restraint evaluation assessment has be completed on resident #14. A consent form with information about side has been sent to his wife. Addendum: She has not returned the form facility as of 2/12/22.	de rails	
	6. Observation on 1/20 two quarter length side resident 17's bed. The this time.	had not been completed. 0/22 at 7:47 a.m. revealed e rails in the up position on e resident was not in bed at 's medical record revealed had not been completed.	F700-6	A restraint assessment has been completed on resident #17. A consent form has been explained and given to him to sign. Addendum: Residenbt #17 has signed the consent form.		
	length side rail in the u of resident 21's bed. T sleeping at this time. Review of resident 21'	0/22 at 1:31 p.m. a quarter up position on the left side the resident was in bed as medical record revealed had not been completed.	F700-7	The side rails have been put down on resident #21's bed. Addendum: The side rails have been zip-tied to prevent staff from utilizing them.		
	p.m. revealed she: *Had one-half side rail *Was seated in her rec *Stated she did use th with repositioning.		F700-8	A restraint evaluation assessment has becompleted on resident #32. A consent form has been given to her to s Addendum: Resident #32 has signed the consent form.		
		had not been completed.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		43A137	B. WING		01/20/2022
NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR		50	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 PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 700	 9. Interview on 1/20/2 practical nurse/Minim revealed an assessm had not been comple side rails. 10. Review of the pro- 	22 at 1:30 p.m. with licensed num Data Set coordinator C nent for the use of side rails ted for residents who used	F 700	Care plans have been updated on resident's #1, 18, 35, 13, 14, 17, 21, and 32 Bed safety assessments are due to be completed a by the QA nurses by the end of Feb of 2022. These be completed on all of the beds in our facility. Restraint evaluation assessments will be complete on the remaining residents that utilize side rails. Consent forms will be presented to the residents.	
	2019 Restraint policy *Staff would have co- intervention and activ- to siderail utilization to *Results of the reside- would have been rev- team, resident/family *Designated interdischave assisted in eval- cognitive status *The interdisciplinary determined the resider safe decision regardiants *Use of the device states	for side rails revealed: mpleted the side rail vities of daily living form prior to assess bed mobility needs. ent's bed mobility needs iewed by the interdisciplinary , and resident's physician. ciplinary team member would fuating the resident's ream would have ent's full ability to make a ng side rail usage. hould have been reviewed disciplinary team, resident,		on the remaining residents that utilize side rails. Consent forms will be presented to the residents/ representatives for these side rails. Care plans wil also be updated on these residents. To assure any future resident that utilizes siderails have the proper restraint assessments completed. The interdispilinary team will report to the QA nurseach week for 2 months, then every other week for 2 months and then once a month for 2 months reports will include which residents reviewed each side rails, have the appropriate assessments and consent forms in place and included in the residen careplans. Addendum: Siderails will be assessed on a quarte or as needed. Addendum: For resident's 35, 21, and any other rewho may have their side rails zip tied to avoid user quality coordinator will check these bed rails on he She will then include the results of these daily cheron.	will e These week utilize ts' srly basis esident age, the r daily rounds.

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STATEMENT OF DEFICIENCIES (X1) PF		(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		NG	co	OMPLETED
		43A137	B. WING			01/20/2022
NAME OF PE	ROVIDER OR SUPPLIER	I III		STREET ADDRESS, CITY, STATE, ZIP CO		
				501 NORTH 4TH STREET		
AVERA BO	RMANN MANOR			PARKSTON, SD 57366		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
PREFIX	Initial Comments Surveyor: 26632 A recertification surve CFR Part 482, Subpa Emergency Prepared Term Care Facilities,	ey for compliance with 42 art B, Subsection 483.73, dness, requirements for Long was conducted from 1/19/22 ara Bormann Manor was	TAG	CROSS-REFERENCED TO TH	IE APPROPRIATE	
LABORATORY	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNATU	JRE	TITLE		(X6) DATE

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

FFR 09 2022

LTC Administrator

2/9/2022

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - MAIN BUILDING 01		(3) DATE SURVEY COMPLETED	
		43A137	B. WING _			1/19/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 501 NORTH 4TH STREET PARKSTON, SD 57366	CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	Life Safety Code (LS occupancy) was cone Bormann Manor was	ey for compliance with the C) (2012 existing health care ducted on 1/19/22. Avera found in compliance with 42 irements for Long Term Care	К 0	00			
LABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATI	URE	TITLE		(X6) DATE	

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

Event ID: VSL521

program participation.

LTC Administrator

South Dakota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ 01/20/2022 B. WING 10660 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 501 N 4TH ST AVERA BORMANN MANOR PARKSTON, SD 57366 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG S 000 S 000 Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/19/22 through 1/20/22. Avera Bormann Manor was found in compliance. S 000 S 000 Compliance/Noncompliance Statement Surveyor: 26632 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/19/22 through 1/20/22. Avera Bormann Manor was found in compliance.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Mary Kummer

TITLE

LTC Administrator

(X6) DATE

2/9/202

STATE FORM

6WSO11

If continuation sheet 1 of 1

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