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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A137	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVERA BORMANN MANOR	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification and complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/9/24 through 7/11/24. Avera Bormann Manor was found not in compliance with the following requirement(s): F558, F604, F684, F880, and past non-compliance at F689.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure one of one sampled resident (13) with hand contractures had a call light she was able to use and was within her reach. Findings include: 1. Observation on 7/9/24 at 10:44 a.m. of resident 13 revealed: *She had hand contractures to both of her hands. *She communicated verbally with yes or no. *She did not have her call light within her reach. Interview on 7/9/24 at 10:44 am. with registered nurse (RN) O in regard to resident 13's use of a call light revealed: *She did not believe resident 13 could push her call light button because her hands were tight due to contractures. *Staff would check on her frequently.	F 558	1) Resident 13 had a soft call light placed on 7/10/24.Resident 13 care plan was updated on 7/30/24. 2) An audit of all residents was completed by the Quality Specialist on 7/31/24 to determine resident's had the most appropriate call device. Care plans were updated for any resident requiring a non-standard call device. 3) Call light policy was reviewed/revised in collaboration with Administrator, DON, IDT, and Medical Director on 7/30/24. A call light safety check will be done on all residents upon admission, quarterly, and upon significant change by nurse. All staff were educated on 7/30/24 regarding call light policy and to ensure placement of call cords within reach of resident prior to exiting the room. Education was presented by the Administrator. *see addendum next page. KJL 8/5/24 4) A call light audit will be completed on four (4) residents per week for three (3) months by the Director of Nursing/ Designee. Data will be brought to the QAPI committee monthly by the Director of Nursing/Designee. Recommendations for further studies will be made by the QAPI committee thereafter.	8/2/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly D. Bonger

TITLE: Administrator

(X6) DATE: 08/01/24

08/05/2024

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.

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F 558	Continued From page 1 Observation and Interview on 7/10/24 at 8:32 a.m. with resident 13 and certified nursing assistant (CNA) Q in regard to resident 13 and use of her call light revealed: *Resident 13 could use her left hand and CNA Q placed the call light in her hand. *She was unable to activate the call light when she held it with her left hand. *He stated he would check on her every hour and a half. Interview on 7/10/24 at 8:41 a.m. with RN N in regard to resident 13 revealed: *Staff were supposed to lay the call light across her, but she could not use the call light. *She stated she had a soft squeeze call light when in her previous room that she was able to use. *She had not had the soft squeeze call light for at least one month and she would get it for her. Observation on 7/10/24 at 2:08 p.m. with resident 13 revealed: *She now had a soft squeeze call light and was able to activate it. Observation and interview on 7/11/24 at 12:37 p.m. with resident 13 and RN N revealed: *She is in a specialized wheelchair. *Her call light was not within her reach, and was clipped to her bed. *She responded yes when asked if she had been up in her wheelchair for a while. *She was given the call light and she activated it. *RN N answered the call light and stated resident 13 had been at chapel and whoever brought her back to her room did not place the call light within her reach.	F 558	Addendum: *A call light audit, to include appropriate type of call light, care plan of call light type, and placement within reach of resident... 8/5/24 KJL	

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F 558	Continued From page 2 Interview on 7/11/24 at 12:55 p.m. with director of nursing (DON) B revealed: *She was aware resident 13 had not had a call light she could use for at least a month. *She stated, "are you kidding me" and shook her head when it was discussed that resident 13 did not have her call light within reach when she was returned to her room after chapel. Review of the provider's call light policy dated 7/2024 revealed: *The objective, "1. To respond to patient/resident's requests and needs on a timely basis." *The procedure noted, "9. A 'soft touch' or bell was available for residents unable to use a standard call light."	F 558		
F 604 SS=G	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 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	F 604		

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F 604	Continued From page 3 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to implement the following for one of one sampled resident (17): *Assess for the use of an audible chair alarm. *Document the use of the chair alarm. *Reassess for the continued use of the chair alarm. *Ensure the audible chair alarm was not causing harm. Findings include: 1. Observation on 7/9/24 at 9:58 a.m. in resident 17's room revealed: *She was seated in her recliner. *There were two alarm devices on her bedside table. One was connected to her bed, and the other was connected to her recliner and shirt. *She was wearing a pendant call light around her neck. *She pressed the pendant call light because she needed to use the bathroom. Staff promptly responded to the call light.	F 604	1) The audible tabs alarm was removed from resident 17 on 7/15/24. A new fall risk assessment was completed on Res 17 on 7/31/24. Silent pressure alarm was discontinued on 7/31/24. 2) All residents who had audible or silent pressure alarms were audited and a new fall risk assessment was completed. All silent & audible alarms have been discontinued as 8/1/24. 3) The restraint policy was reviewed in collaboration with Administrator, DON, IDT, and Medical Director on 7/30/24. All Staff were educated on 7/30/24 by Director of Nursing to the restraint policy, to include the discontinued use of alarms and role in identifying person centered interventions for fall prevention. 4)An audit of four (4) residents per week for three (3) months will be done by the MDS Coordinator/Designee to identify any device for potential restraint and ensure a restraint assessment is completed. Data will be brought to QAPI committee monthly by the Director of Nursing/Designee. Recommendations for further studies will be made by the QAPI committee thereafter.	08/02/2024

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F 604	Continued From page 4 2. Observation and interview on 7/9/24 at 2:04 p.m. with resident 17 in her room revealed she: *Was seated in the same recliner. *Showed the surveyor a chair alarm was clipped to her shirt. *Was able to explain the purpose of the alarm. *Explained that it made a noise if she tried to move. *Said, "I don't like it. It's loud and scares me. They don't want me to get up by myself." 3. Observation on 7/10/24 at around 12:55 p.m. near resident 17's room revealed that there was a loud and pulsating alarm emitting from her room. 4. Interview on 7/10/24 at 4:24 p.m. with certified nursing assistant (CNA) J about resident 17's chair alarm revealed: *She denied that the alarm physically restrained the resident, indicating that the resident could easily move, and the string attached to the resident's clothing would detach. *When she heard the alarm, she would have gone running to attend to the resident because she was a fall risk. *The resident had fallen previously and was bruised from the fall. *Resident 17 knew how to use the call light. *The resident usually attempted to get up by herself when she needed to use the bathroom. 5. Interview on 7/11/24 at 8:44 a.m. with director of nursing (DON) B about the chair alarms revealed: *If a resident tended to get up on their own and was not "the safest" to ambulate by themselves, they would place a "tabs alarm" on the resident. *The alarm would be clipped to the back of a resident's shirt so they would not be able to	F 604		

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F 604	Continued From page 5 remove it easily. *She confirmed there was no assessment process prior to implementing a "tabs alarm." *The bed alarms were silent. -If the bed alarm was triggered, the resident's call light would turn on. *The "tabs alarms" were loud and audible. -If the resident moved a certain way, the "tabs alarm" would become disconnected and emit a loud and audible alarm. *She confirmed there was no assessment to determine if the resident felt restrained by the device. *She had not considered if the resident could have been frightened by the audible chair alarm. 6. Interview on 7/11/24 at 9:34 a.m. with registered nurse (RN) N about the audible chair alarms revealed: *If a resident had an unwitnessed fall, the first intervention was usually to have placed the "tabs alarm" on the resident. *If a fall occurred, the resident's family would have been contacted to inform them of the fall and the implementation of the "tabs alarm." *Other fall prevention interventions included signage in the resident's rooms to remind them to "call don't fall." *Resident 17 was a patient in the adjoining hospital prior to her admission to the nursing home and received physical and occupational therapy to improve her strength and balance after she broke her hip from a fall at her previous living accommodations. *Resident 17 was more forgetful when she first admitted to the nursing home and would shout out for help rather than using her call light. -She understood how to use the call light now. -The resident had a habit of using the call light	F 604		

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F 604	Continued From page 6 and standing up immediately rather than waiting for help to arrive. -"She doesn't like to wait." 7. Review of resident 17's electronic medical record revealed: *She was admitted on 6/14/24. *Her Brief Interview for Mental Status (BIMS) score was 11, which indicated she had moderate cognitive impairment. *There was no documentation of when the audible chair alarm was implemented. *There was no assessment to determine if the use of the audible chair alarm was appropriate or if it was a restraint. *There was no physician's order or duration of use for the audible chair alarm. *Her care plan included the following under the "Fall risk" problem initiated on 6/16/24: -An intervention of "Mobility Alarm...sensory pad on in chair and in bed" with a start date of 6/25/24. --A frequency of "Every 8 Hours" was attached to the intervention for the silent bed alarm only, not the audible chair alarm. -There were no other interventions for the audible chair alarm on her care plan. 8. Review of the provider's 6/23 Falls and Accidents policy revealed: *Purpose: "To be proactive in preventing resident falls and accidents." *Policy Statement: "To provide a systematic approach to fall and accident prevention and monitoring, including identifying and evaluating hazards and risk, individualizing approaches to reduce the risk of falls and accidents, and monitoring for effectiveness of interventions when necessary."	F 604		

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F 604	Continued From page 7 *Definitions: "Position change alarms: alerting devices intended to monitor a resident's movement. -The devices emit an audible signal when the resident moves in a certain way. -Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clip[ped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors." *Policy implementation: -"2. Resident assessment and intervention --A. Upon admission/readmission, quarterly, and with status changes, staff will assess each resident's individual risk factors including fall risk, elopement risk, and risks and hazards within the physical environment. --B. Based on assessment of fall risk and elopement risk for each resident, staff will implement appropriate individualized, resident-centered interventions to reduce the likelihood of falls and elopement and communicate the risk and intervention to the staff through the plan of care. --C. Effectiveness and modification of interventions is monitored on a regular basis by the QAPI [quality assurance and performance improvement] program." -"...4. Hazards in the physical environment --A. Staff will ongoingly assess the physical environment with regard to potential hazards, including...position change alarms...resident mobility devices... Any deficiencies in the safety of the physical environment will be immediately addressed. --...C. The resident care plan will specifically address any risk factors that provide a benefit, such as use of a side rail or mobility device. --...E. The facility will provide adequate supervision through assessing the appropriate	F 604		

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F 604	Continued From page 8 level and number of staff, the competency and training of staff, and the frequency of supervision needed based on resident needs." 9. Review of the provider's 5/24 Restraint Policy revealed: *Policy Statement: "It is the philosophy of Avera LTC [long term care] to keep residents unrestrained and as independent as possible. -If the results of a comprehensive, interdisciplinary assessment determine that there are no alternative to provide resident safety, or that the alternative methods have been unsuccessful, a physical and/or chemical restraint will be recommended for use." *Definitions: "Physical restraint: any manual or physical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. -Physical restraints include but are not limited to leg or arm restraints, bolster mattresses, hand mitts, soft ties or vests, leg cushions and lap trays the resident cannot remove, and tucking a sheet around a resident so that resident cannot move." *Policy Implementation: -"1. Members of an interdisciplinary team (IDT) will evaluate the resident's safety needs. -2. If a problem is identified, the least restrictive method will be tried first and the results documented. The use of restraints shall require clinical justification and shall be employed only to protect a resident from self-injury or from injuring others. -Restraints must not be used to limit mobility, for convenience of staff, for punishment, or as a substitute for supervision... -3. If a restrains is found to be necessary,	F 604		

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F 604	Continued From page 9 appropriate health professional will complete the Pre-Restraining intervention in the electronic health record (EHR). The assessment will include medical condition requiring need for restrain and will be documented in the intervention. -4. Physician notification is required for all restraints initiated and a [physician's] order must be obtained prior to implementation. Restraint orders must be specific and include: type of restraint, specific periods of time restraint is to be used, medical symptom for restraint use, check by staff every 30 minutes, release every 2 hours, and specific times when restraint can be removed. -5. Resident and family will be educated on restraint use, reasons for use, assessment results, and risks and benefits associated with restraint use. -6. Resident or resident's family must sign a consent form for restraint use. -...8. Interdisciplinary team and physician will evaluate restraint usage monthly at minimum and will be reviewed at quarterly care conference by care planning team, resident and resident's family. -9. Restraints must be routinely observed and assessed. The restraints are to be periodically removed and range of motion, massage, or exercise applied, and hygiene, nutrition, and toileting offered. -a. Staff will check the resident's restraint every 30 minutes. -10. Quarterly documentation of attempted restraint reduction will be completed in the Restraint Assessment and noted on all applicable MDS [Minimum Data Set] assessments on the CAAs [care area assessments]. Early release and alternatives to restraint are to be continually explored."	F 604		

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F 604	Continued From page 10 10. Review of the provider's 3/24 Transfers policy revealed: *"Purpose: To establish a protocol for staff for proper transfer techniques and decrease risk of injury to self and patient." *"Protocols: Transfer Set-up: -...7. Put on tabs monitor or safety devices if needed and give call light (if inpatient or NH [nursing home])."	F 604		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two certified nursing assistants (H and K): *Applied a mechanical stand aide sling to sampled resident (22) prior to use. *Transferred a sampled resident (22) safely from the bathroom to a specialized wheelchair. *Received documented training for the use of a mechanical stand aide and resident transfers using a specialized wheelchair (Broda chair). Findings include: 1. Observation on 7/9/24 at 2:22 p.m. in resident 22's room revealed:	F 684	1) Resident 22 will be transferred using sit to stand and BRODA chair according to manufacturer's recommendations. CNA H&K were educated by DON & competency completed on 7/30/24. 2) No resident will be transferred using the sit to stand lift prior to sling being placed. All BRODA chairs will remain on all four wheels during resident transfer. 3) All direct care staff were re-educated to the correct way to use the mechanical lift and had a competency completed by the Director of Nursing on 7/30/24. Education to BRODA safety was also completed by DON on 7/30/24 to all direct care staff. 4) A mechanical lift transfer audit will be completed to include residents who require a BRODA on two (2) residents weekly for 3 months by the Director of Nursing.Data will be brought to the QAPI committee monthly by the Director of Nursing/Designee. Recommendations for further studies will be made by the QAPI committee thereafter.	08/02/2024

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F 684	Continued From page 11 *Resident 22 was resting in his recliner. *Certified nursing assistant (CNA) H and K entered his room to assist him with transferring him from the recliner to his Broda (specialized) wheelchair. *They used the recliner remote to lift him upwards. *They positioned the mechanical stand aide in front of resident 22 and placed his feet on the footboard. *They guided his hands up to the handlebars and instructed him to hold on. *Without strapping the mechanical stand aide sling around him, CNA H raised the mechanical stand aide slightly so that resident 22 was standing up from the recliner. -He was visibly shaking and appeared to have been struggling to hold on. *While he was standing, CNA K put the sling behind the resident and CNA H then seated him back down into the recliner. *With the sling correctly placed around resident 22 and hooked into the mechanical stand aide, they raised him from his recliner to a standing position and transferred him to the bathroom, positioned him onto the toilet, and then exited his room. 2. Continued observation on 7/9/24 at 2:43 p.m. in resident 22's room revealed: *CNAs H and K reentered resident 22's room and attended to his needs in the bathroom. *They transferred him out of the bathroom using the same mechanical stand aide. *CNA H positioned resident 22 in front of his Broda chair. *CNA H instructed CNA K to go behind the Broda chair and lift the back two wheels off the ground to tilt the chair forward.	F 684		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 -As CNA K held up the Broda chair, CNA H lowered resident 22 down into the Broda chair. *It was unknown if the wheels of the Broda chair were locked or not during the transfer. 3. Interview on 7/9/24 at 5:57 p.m. with CNA K about the above observation revealed: *She confirmed she was taught to lift the back wheels of resident 22's Broda chair upwards to tilt the chair forwards to easily position the resident all the way into the chair. *She said, "He's a stiff guy," so they tried to tilt the chair to get him into the correct position when they transferred him into the Broda chair. 4. Interview on 7/9/24 at 4:44 p.m. with CNA H about the above observation revealed: *She confirmed the way staff had "figured out" how to get resident 22 correctly positioned into the Broda chair was to tilt the back end up the chair upwards. *She said, "Since he is so tall and still, he doesn't bend much. We have to tilt it up to get him all the way in." *She indicated they had tried other methods, but he was not able to sit all the way back into his wheelchair. -In those cases, they required three people to hoist him into the Broda chair. *She was educated to tilt the Broda chair forward to transfer him into the chair. She did not recall who instructed her. 5. Interview on 7/10/24 at 12:55 p.m. with registered nurse (RN) M about the above observation revealed: *She was aware that staff lifted the back wheels of resident 22's Broda chair to tilt it forward to position him all the way into the chair.	F 684		

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	43A137	A. BUILDING _____ B. WING _____	C 07/11/2024

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AVERA BORMANN MANOR	501 NORTH 4TH STREET PARKSTON, SD 57366

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F 684	Continued From page 13 *She said that "he is a stuff guy" and had a difficult time bending to sit in the chair. *She confirmed there were functioning brakes available to use on all four wheels of the Broda chair. 6. Interview on 7/10/24 at 1:28 p.m. with CNA P about how to safely transfer resident 22 revealed: *She was able to state the correct procedure of placing the mechanical stand aide sling on the resident prior to lifting the resident with the mechanical stand aide. *She was not aware of the tilting method to place resident 22 into his Broda chair. 7. Continued interview on 7/10/24 at 1:33 p.m. with RN M about how to safely transfer resident 22 revealed: *She would have expected staff to have placed the sling around the resident first and to ensure it was secure prior to lifting the resident with the mechanical stand aide. 8. Interview on 7/11/24 at 8:58 a.m. with director on nursing B about how to safely transfer resident 22 revealed: *She would have expected staff to have secured the sling around the resident prior to lifting the resident with the mechanical stand aide. *She was not aware staff were lifting the back two wheels of his Broda chair to place him in the chair. -"That's not the best thing for staff to do either due to safety concerns." *She confirmed there was no documentation that supported either CNA had been educated on how to properly operate the mechanical stand aide or the Broda chair.	F 684		

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F 684	Continued From page 14 9. Review of resident 22's electronic medical record revealed: *He required extensive to total staff assistance with activities of daily living due to the late stages of dementia. *His care plan indicated to use the Broda chair. However, there was nothing in the care plan that instructed staff to lift the back two wheels of the chair to place him in the chair. 10. Review of the provider's 3/24 Transfers policy revealed: *"Purpose: To establish a protocol for staff for proper transfer techniques and decrease risk of injury to self and patient." *"Protocols: Transfer Set-up: -1. Check physician's order and care plan to see if restrictions and weight bearing status. -...4. Lock all transfer surfaces. -5. Put transfer belt on patient." 11. Review of the January 2007 manufacturer's operating instructions for the Broda chair revealed the manual did not indicate if it was an acceptable practice to lift the back two wheels off the floor to tilt the chair forward during a resident transfer. 12. Review of the 7/30/18 manufacturer's operator's instructions for the mechanical stand aide revealed: *Page 5, "Transferring the patient: -Attach harness --1) Position the harness around the upper body of the patient so the sides of the harness are between the patient's torso and arm, resting 2 - 3 inches below the underarm. --2) For the safety of the patient, securely fasten the safety strap around the patient's torso.	F 684		

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F 684	Continued From page 15 --3) Secure the buckle and pull the strap to tighten." *The manual further explained the following steps prior to raising the patient: position shin pad and foot plate, position the mechanical stand aide in front of patient, and attach harness to the mechanical stand aide. *There was a warning on page 7 that read, "Patient MUST ALWAYS wear the harness when using the [mechanical stand aide]. It can be helpful to use the seat strap or support strap during ambulation." *The manual indicated to lock the wheelchair/chair/bed/transfer surface prior to lowering the patient down onto that surface.	F 684		
F 689 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), record review, interview, and observation, the provider failed to ensure the safety of one of one sampled resident (47) who eloped from the facility (left without staff's knowledge) and failed to report the elopement within the required timeframe. Failure to ensure safety could have led to resident injury had he not been found. This citation is considered past non-compliance based on review of the	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 16 corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 6/24/24 SD DOH FRI revealed: *Resident 47 was admitted to the nursing home on 6/17/24. He was previously living at the adjoining assisted living facility. *At around 5:15 p.m., director of plant operations E found resident 47 near the adjoining hospital entrance. *The resident was brought back to the nursing home. *A wander bracelet was put in place afterward. *The door alarms were functioning at the time of the incident. *The resident was not injured. *The nurse on staff that day was not aware that the incident was regarded as an elopement since the resident did not leave the campus. *All staff were reeducated about elopement and reporting requirements. The provider implemented systemic changes to ensure the deficient practice does not recur was confirmed after: *Observations throughout the survey of resident 47 revealed that his wander bracelet was in place and functioning. *Interviews with staff (certified nursing assistants, registered nurses, maintenance staff, and the management team) confirmed they knew the reporting requirements for elopement and were aware of the procedures to address a resident who had eloped. *Record review confirmed staff were regularly checking for wander bracelet placement and functioning, the interventions were added to	F 689		

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F 689	Continued From page 17 resident 47's care plan, and education was provided to all direct care staff regarding missing residents and reporting requirements. Based on the above information, non-compliance at F689 occurred on 6/17/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 6/30/24, the non-compliance is considered past non-compliance.	F 689		
F 880 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	1) CNAs H & K were re-educated to the infection control practices regarding hand hygiene and disenfection of lifts on 7/30/24 by Director of Nursing. 2) Hand hygiene will be completed per policy during resident cares. Lifts will be sanitized after each resident use prior to storage. 3) All staff were re-educated to the hand hygeine policy and sanitation of equipment on 7/30/24 by the Director of Nursing. 4) A hand hygeine audit and sanitation audit will be done on five (5) direct care employees and audit of (2) mechanical lift audits per week for three (3) months by the Quality Specialist/Designee. Data will be brought to QAPI monthly by the Director of Nursing/Designee. Recommendations for further studies will be made by the QAPI committee thereafter.	08/02/24

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F 880	Continued From page 18 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 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.	F 880		

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F 880	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure current infection control policies for hand hygiene and mechanical lift disinfection were followed by two of five staff observed (certified nursing assistant (CNA) H and K). Findings include: 1. Observation on 7/9/24 at 2:22 p.m. with CNAs H and K during a transfer with resident 22 revealed: *The CNAs entered resident 22's room and discovered the hand sanitizer dispenser was empty. *CNA H exited the room to retrieve a new bottle of hand sanitizer. *CNA K proceeded to put on a clean pair of gloves without performing hand hygiene. *CNA H came back into the room and stated she could not find a new bottle of hand sanitizer. -She proceeded to put on a clean pair of gloves without performing hand hygiene. *They assisted resident 22 to stand up from his recliner using the mechanical stand aide. *While he was standing, CNA K checked his brief and discovered he was incontinent. *The CNAs brought him into his bathroom. *A few minutes later, CNA H came out of the bathroom without gloves on. -She grabbed a clean pair of gloves and brought them to the bathroom. -She came back out of his bathroom and left the resident's room without performing hand hygiene to find hand sanitizer. *CNA K exited the resident's room with a bag of trash. -She performed hand hygiene in the handwashing sink in the hallway after throwing out the trash.	F 880		

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F 880	Continued From page 20 *The two CNAs left the resident on the toilet so he could finish going to the bathroom. 2. Observation on 7/9/24 at 2:43 p.m. with CNAs H and K in resident 22's room revealed: *They returned to transfer resident 22 from the bathroom to his Broda chair. *They both performed hand hygiene prior to putting on clean gloves. *After they were finished transferring, they placed the mechanical stand aide in the hallway. *Neither of them sanitized the stand aide prior to moving on to a different task. -There was a container of sanitizer wipes available in a pouch on the stand aide. 3. Interview on 7/10/24 at 2:59 p.m. with registered nurse (RN) N about the above observations revealed: *It was her expectation that: -Staff should have performed hand hygiene prior to putting on gloves. -Staff should have performed hand hygiene after removing gloves. -If the hand sanitizer dispenser was empty, they should have retrieved a new container. -If a new container was not available, staff should have washed their hands with soap and water. -Staff should have sanitized the lift equipment after each use. 4. Interview on 7/10/24 at 3:44 p.m. with infection preventionist G about the above observations revealed: *It was her expectation that: -Staff should have washed their hands with soap and water if hand sanitizer was not available. -The mechanical lifts should have been sanitized after each use. There was a container of sanitizer	F 880		

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F 880	Continued From page 21 wipes with each mechanical lift. 5. Review of the provider's 5/24 Hand Hygiene policy revealed: *"Purpose: Hand hygiene is the single most important procedure for the control of infection. It is a critical component of patient and employee safety." *"Policy: I. Indications and Procedure for Hand Hygiene" -A. Hand Hygiene with Soap and Water: 1. Wash hands with system approved soap and water: --a. When hands are visibly dirty. --b. When hands are contaminated with proteinaceous material. --c. When hands are visibly soiled with blood or other body fluid... -B. Hand Hygiene with Alcohol Hand Rub (Antisepsis): 1. If hands are not visibly soiled, use system approved alcohol-based hand rub for routinely decontaminating hands in most other clinical situations: --a. Before each patient contact. --b. Before donning sterile gloves... --...d. After routine patient care (e.g., taking vital signs, lifting/positioning/ambulating a patient) where there is no contact with body fluids. --e. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. --f. After glove removal." 6. Review of the provider's 5/23/24 Disinfection of Non-Critical Resident Care Equipment policy revealed: *"I. Purpose: -...C. For the safety and comfort of residents, all reusable ("non-critical") resident care items will be cleaned, disinfected, fand maintained in a safe	F 880		

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F 880	Continued From page 22 manner between resident uses." *"II. Information: -A. Reusable resident care equipment/items fall into 3 different classification categories for disinfection and sterilization: 'non-critical, semi-critical, and critical.' --1. 'Non-Critical' items are those that come into contact with intact skin but not mucous membranes. These are divided into resident care items and environmental surfaces. ---a. Noncritical resident care items (Examples include blood pressure cuffs, stethoscopes, wheelchairs, therapy equipment) are cleaned between/after each resident use. They require Low level disinfection by cleaning following manufacturer instructions with an EPA [Environmental Protection Agency]-registered disinfectant, detergent, or germicide that is approved for healthcare settings..." *"III. Policy: -A. Community/facility items removed from a resident's room needs to be disinfected prior to use by a different resident. -B. Resident equipment will be disinfected immediately following resident use when the item has been contaminated with blood or other potentially infectious material or is visibly soiled. -...D. All reusable resident care equipment removed from a resident room/procedure room is disinfected before use on another resident. -...J. Disinfection Recommendations- --1. Reusable resident care equipment: All applicable label instructions on EPA-registered disinfectant products must be followed. ---a. Between each resident use and when soiled. ...f. Lifts & slings. -...M. Monitoring of disinfection recommendations will be done by observation by management staff and no written documentation is required.	F 880		

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F 880	Continued From page 23 However, to maintain continuity, units may maintain a worksheet with cleaning/disinfection schedules.	F 880		

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

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 7/10/24. Avera Bormann Manor was found in compliance.	E 000		

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

TITLE: Administrator

(X6) DATE: 07/31/2024

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.

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

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	43A137	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2024**

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/10/24. Avera Bormann Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Administrator | 07/31/2024

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South Dakota Department of Health

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	10660	A. BUILDING: _____ B. WING _____	C 07/11/2024

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AVERA BORMANN MANOR	501 N 4TH ST 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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 7/9/24 through 7/11/24. Avera Bormann Manor was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/9/24 through 7/11/24. Avera Bormann Manor was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 07/31/2024