

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	--	---

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

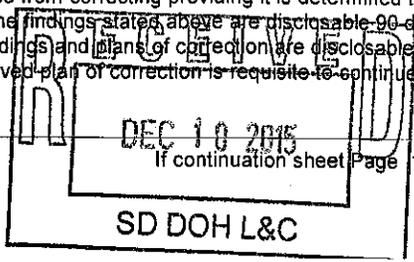
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><i>*Addendums noted with an asterisk per 12/23/15</i></p> <p>INITIAL COMMENTS <i>Per telephone with facility</i></p> <p>Surveyor: 32335 <i>DON. KG/SDD/HEL</i></p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 11/16/15 through 11/18/15. Avera Bormann Manor was found not in compliance with the following requirement(s): F221, F226, F280, F314, F441, and F520.</p>	F 000		
F 221 SS=E	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35237 Based on observation, record review, interview, manufacturer's instructions review, and policy review, the provider failed to: *Use appropriate seatbelt devices for three of three sampled residents (1, 3, and 9) with seatbelt restraints. *Ensure assessments for trunk (upper body), hand, and bed restraints were completed at least quarterly for two of two sampled residents (1 and 3). Findings include: 1. Observation on 11/16/15 at 4:30 p.m. of resident 3 revealed he: *Was in his room sitting in a Broda (special type) wheelchair. *Had a full hand mitten (mitt) over his right hand.</p>	F 221	<p>F221</p> <ol style="list-style-type: none"> The gait belt for resident #3 has been eliminated and replaced with a Velcro seat belt. A restraint elimination assessment has been completed which addresses the need for the seat belt, hand mitt and posey net bed. A restraint elimination assessment has also been completed on resident #1. Her gait belt has been eliminated and replaced with a Velcro seat belt. The gait belt in use for Resident #9 has also been eliminated and replaced with a Velcro seat belt. A restraint elimination assessment has been completed and addresses the need for the seat belt. 	

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

[Signature] *President/C.E.O.* *12-9-15*

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 1</p> <p>*Had a gait belt (belt around waist typically used to assist with walking/moving) secured around his waist to around the back of the Broda chair. -The buckle of the belt was in the back of the Broda chair.</p> <p>Observation on 11/17/15 at 8:00 a.m. of resident 3 in his bed revealed: *He had a fabric tent over his bed. *The tent was zipped close on both sides of his bed leaving the bottom of the bed open. *He had a full hand mitt over his right hand.</p> <p>Observation and interview on 11/17/15 at 9:30 a.m. with certified nursing assistants (CNA) C and D during resident 3's morning care and transfer from the bed to his Broda chair revealed: *The tent "keeps him safe, because he rolls out of bed." *The right hand mitt was "so he doesn't pull his feeding tube (surgically inserted tube into the stomach for medications and nutrition) out again." *Once they transferred him to his Broda chair: -They secured two gait belts together. -Placed the belts around his waist and the back of his Broda chair. -Secured the gait belt with the buckle behind the Broda chair. -Stated they needed two gait belts together, because one was too short to go around him and the wheelchair. -Stated he "has seizures [severe uncontrolled movements] so he gets strapped in," and the belt was to keep him from sliding out of the wheelchair.</p> <p>Review of resident 3's 1/23/15, 7/20/15, and 10/2/15 Minimum Data Set (MDS) assessments revealed:</p>	F 221	<p>To assure proper use of restraints for future residents, a restraint elimination assessment will be completed on all restraints at least quarterly. Nursing staff will be re-educated on the Avera restraint policy and procedure and also on appropriate gait belt use. Licensed nurses will be given education on completing the restraint elimination assessment in the meditech system.</p> <p>This education in-service will be completed by Dec. 19th, 2015.</p> <p>The DON or designee will audit each of the 3 residents and any other residents with restraints, particularly looking at the Restraint Elimination Intervention. This audit will be completed once a month X 3 months then once a quarter X2 quarters. Results of audits will be reported to the QA committee. The QA committee will decide if any further action is necessary.</p>	1/7/16	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	<p>Continued From page 2</p> <p>*He sometimes had the ability to understand others.</p> <p>*He required total assistance from staff to complete his activities of daily living (ADL; bathing, moving around, toileting, hygiene, and eating).</p> <p>*In bed he had a "limb [arms/legs]" and "other" restraint.</p> <p>*Out of bed he had a "trunk" and "limb" restraint.</p> <p>Review of resident 3's 10/8/15 care plan revealed:</p> <p>*Restrains had been identified as a problem area.</p> <p>*The restraints being used had included the following:</p> <ul style="list-style-type: none"> -Hand mitt. -Posey net bed frame. -Seat belt. --It did not mention using gait belts as the seat belt. <p>Review of resident 3's medical record revealed:</p> <p>*The only restraint assessment for the last year had been completed on 5/29/15.</p> <ul style="list-style-type: none"> -That assessment only mentioned the trunk restraint. *There were no assessments related to the net bed frame or the hand mitt. <p>2. Random observations from 11/16/15 through 11/18/15 of resident 1 revealed she:</p> <p>*Utilized a Broda wheelchair to move around the facility.</p> <ul style="list-style-type: none"> -She could propel the wheelchair herself or had staff assistance at times. *When she was in the Broda chair she had a gait belt secured around her waist to around the back of the chair. 	F 221		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 3</p> <p>-The buckle of that belt was secured in the back of the chair.</p> <p>Observation and interview on 11/17/15 at 9:00 a.m. with CNAs E and F during resident 1's care revealed they:</p> <p>*Transferred her from the Broda wheelchair to the toilet and back to the wheelchair when she was finished.</p> <p>*Once she was in her Broda chair they:</p> <p>-Placed a gait belt around her waist and the back of her Broda chair.</p> <p>-Secured the gait belt with the buckle behind the Broda chair.</p> <p>*Stated the gaitbelt around her waist and the wheelchair was the "seatbelt."</p> <p>*Stated she frequently attempted to get up by herself, and it was to keep her from falling.</p> <p>Review of resident 1's 3/16/15, 5/29/15, and 8/21/15 Minimum Data Set (MDS) assessments revealed:</p> <p>*She sometimes had the ability to understand others.</p> <p>*She required extensive assistance from staff to complete her ADLs.</p> <p>*Out of bed she had a "trunk" restraint.</p> <p>Review of resident 1's 8/27/15 care plan revealed:</p> <p>*Restraint had been identified as a problem area.</p> <p>*The restraint was a seat belt when she was in the Broda chair.</p> <p>-It did not mention using a gait belt as the seat belt.</p> <p>Review of resident 1's medical record revealed there had been no restraint assessments completed on the seat belt for the last year.</p>	F 221			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	Continued From page 4 3. Random observations from 11/17/15 through 11/18/15 of resident 9 revealed he: *Utilized a wheelchair to move around the facility. -He could propel the wheelchair himself and had staff assistance at times. *Had a gait belt secured around his waist to around the back of the wheelchair. -The buckle of the belt was in the back of the wheelchair. Review of resident 9's 8/29/15 Minimum Data Set (MDS) assessment revealed: *He had short term and long term memory problems and moderately impaired decision making ability. *He required extensive assistance from staff to complete his ADLs. *Restraints had not been used at that time. Review of resident 9's 9/1/15 care plan revealed: *Restraint had not been identified as a problem area. *The gait belt being used as a seat belt when he was in his wheelchair was not mentioned. Review of resident 9's medical record revealed there was an initial restraint assessment completed on the seat belt restraint on 10/15/15. 4. Interview on 11/17/15 at 1:15 p.m. with the director of nursing (DON) revealed: *Residents 1 and 3 would not have been able to release the gait belt (seat belt) on their own. -The gait belts were being used as restraints. *The facility had used the gait belts as a seat belt for a long time. *They had not thought of ordering a "true" seat belt for their wheelchairs.	F 221			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	<p>Continued From page 5</p> <p>*She agreed assessments should have been completed for any restraint a resident used, and those should have been done quarterly.</p> <p>Interview and record review on 11/17/15 at 1:45 p.m. with the DON and the MDS assessment nurse regarding restraint assessments revealed: *The assessments had not been completed quarterly and should have been. *The nurses had been doing restraint documentation on the status board (a section of their electronic software). -That documentation had not flowed to the actual medical record. *They confirmed the status board charting related to restraints: -Had no evidence a nurse had completed that documentation. -Was not a complete assessment of the restraints. -Had no evidence of the date or time the documentation was entered or edited. -Was not part of the resident's permanent medical record.</p> <p>Interview on 11/17/15 at 3:30 p.m. with registered nurse (RN) G regarding restraints and assessments revealed: *Nurses were documenting on restraints in the status board at times; those were not specifically an assessment. *She would have done an initial restraint assessment when it was started for a resident, but the charge nurse would not do the quarterly assessments after that. *She agreed restraints should have ongoing, at least quarterly, assessments completed.</p> <p>Interview on 11/17/15 at 5:50 p.m. with RN H</p>	F 221		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	<p>Continued From page 6</p> <p>revealed:</p> <ul style="list-style-type: none"> *Using a gait belt around a resident's waist and the wheelchair was considered a restraint. *Restraining a resident with a gait belt was not the intended purpose of a gait belt. *She agreed nurses should have completed restraint assessments at least quarterly. <p>Interview on 11/18/15 at 8:10 a.m. with RN K regarding restraints revealed:</p> <ul style="list-style-type: none"> *Residents 1, 3, and 9 used the gait belts as seats belts when in their wheelchairs. *They were not able to release those gait belts on their own. -Would have been considered restraints. *Staff used to put resident 9's gait belt with the buckle in the front, but he was able to get it off on his own then. *Now they placed the buckles in the back of the wheelchairs. <p>Interview on 11/18/15 at 9:45 a.m. with physical therapy technician I and physical therapist J revealed gait belts were intended to be used as a transfer or assistive device. They were not meant to be used as a restraint.</p> <p>Further interview on 11/18/15 at 10:20 a.m. with the DON regarding restraints revealed:</p> <ul style="list-style-type: none"> *They had received a deficiency during the previous survey in November 2014 for not completing quarterly assessments for restraints. *According to their plan of correction from that previous survey: -They should have been doing quarterly restraint assessments and that had not been done. -They had been doing audits on the areas they had received deficiencies on which included restraints. 	F 221			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	<p>Continued From page 7</p> <p>-Those audits were completed by her or a designee and were supposed to be taken to the quality assurance committee for review. *Review of those audits during the interview revealed:</p> <p>-There was no mention of specifically what was reviewed related to restraints. -There was documentation restraint assessments had not been completed, but no mention of what they did to address that. *She agreed there was still a system problem with completing the quarterly restraint assessments. *There was "no good reason" they were using gait belts as seat belts versus an actual seat belt. *She confirmed it was not the intended purpose of a gait belt to use it as a restraint. -There were several other options of restraints that could be purchased or used.</p> <p>Review of the provider's January 2013 Restraints/Protective Devices policy revealed: *"Restraints will be applied in the least restrictive manner possible and in accordance with safe and appropriate restraining techniques." *"The resident is reassessed quarterly and as needed."</p> <p>Review of the 2013 Posey Gait and Transfer Belt instruction manual revealed: *The recommended use was for "residents requiring ambulation and/or transfer assistance." *"NOTE: This product is not intended for use as a restraint. Remove after each use." *"WARNING: Never apply a Gait Belt or Transfer Belt if there is any compromise of safety or indication of inappropriateness to the patient or caregiver." *"WARNING: Never use a Gait or Transfer Belt</p>	F 221		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 221	Continued From page 8 as a seat belt or to position a person in a chair or vehicle. Gait and Transfer Belts are not designed for seat positioning..."	F 221			
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to: *Thoroughly investigate and report to the South Dakota Department of Health (SD DOH) an incident (abnormal event) for one of one sampled resident (2) that resulted in a major injury. *Thoroughly investigate incidents with minor or no injury for two of two sampled residents (7 and 9). Findings include: 1. Review of resident 2's medical record revealed she had a fall on 5/26/15 that resulted in a hip fracture. Review of the provider's 5/26/15 computerized incident report regarding resident 2 revealed: *She fell at 0652 (6:52 a.m.). *She was found on the floor by her roommates dresser. *She was lying on her right side, and her right foot was rotated outward. *The call light had not been within reach, but she	F 226	1. Unfortunately we cannot go back and notify the DOH on incident involving resident #2 2. Unfortunately time has passed and we are unable to investigate bruising on resident #7 3. The care plan on resident #9 has been updated to reflect his specific verbal and physical behaviors and interventions to help with these. Unfortunately we cannot go back and fill in documentation on the incident that occurred on 11/7/15. All nurses have been re-educated to the SD reporting requirements and were given instructions on how to access on-line forms. Discussion also included types of incidents that require DOH notification and time		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 9 had been instructed to use it. *The last time staff had contact with the resident was at 0200 (2:00 a.m.). *The resident had been confused prior to the fall. *The corrective action had been surgical intervention for a fractured right hip. *They had not reported the incident to the SD DOH or any other agencies. *There had been no other documentation regarding the investigation into what she had been doing prior to the fall, who had been working with her, environmental concerns, why the call light had not been within reach, or if the care plan had been followed.</p> <p>Review of resident 2's 5/2/15 Minimum Data Set (MDS) assessment revealed her thinking ability was severely impaired. She required limited assistance from one staff person to use the bathroom.</p> <p>2. Review of a twenty-four hour event report sent to the SD DOH regarding resident 7 revealed: *She had bruising on the bottom of her left foot that resembled a hand or fingerprints. *There had been a larger area and two smaller areas, dark purple in color. *Staff had been interviewed. -"Some suggest it could have happened by transferring with the Hoyer [equipment used to transfer a resident in a sling from one place to another] lift or when restorative therapy is being done on resident." *There had been no documentation regarding if restorative staff worked with her without her shoes on to cause the bruise or how transferring with a Hoyer lift would have caused a bruise on the bottom of her foot. *There had been no documentation on who had</p>	F 226	<p>lines for reporting. Nurses were also instructed to continue follow-up documentation X48 hours or more after any incident reported. This in-service was held on 12/2/15.</p> <p>To ensure that future incidents are reported and investigated as required, the DON or designee and SSC will review all incident reports, whether requiring DOH notification or not (in a timely manner) and document investigation results.</p> <p>The DON or designee will audit incident report investigations for timely completion on a weekly basis X4 weeks then on a monthly basis X2 months, than once a quarter X2. Results of these audits will be reported to the QA committee monthly. QA will address further action needed after each month of reports. Our policy and procedure on incident reporting and investigation has been updated to reflect the above plan.</p>	11/7/16	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 10 been working with her that day.</p> <p>Review of the undated documented staff interviews revealed answers varied as to how long the bruise had been there. Six staff members had stated they had seen it last week but had not investigated it. Wednesday, Friday, and Saturday were days mentioned that it had been seen. Others had not been aware of the bruise.</p> <p>Review of resident 7's 10/9/15 MDS assessment revealed she had short and long term memory problems. She required total assistance of two staff members to transfer from place-to-place, get dressed, and use the bathroom.</p> <p>3. Interview on 11/18/15 at 3:00 p.m. with the director of nursing (DON) revealed they had not: *Reported the incident regarding resident 2 to the SD DOH. *Thoroughly investigated the incidents regarding resident 2 and 7.</p> <p>Surveyor: 35237</p> <p>4. Review of resident 9's medical record revealed: *He had diagnoses of Alzheimer's (impaired memory and decision making) disease and anxiety (nervousness). *His physician's orders included: -An antipsychotic (used to manage psychosis [delusion, hallucinations, or disordered thoughts]) medication twice a day and as needed. -An antianxiety (used to treat anxiousness) medication as needed. *On 11/7/15, "res [resident] flipped another res wheelchair over with res in it." -Specific cause was listed as "Behavior,</p>	F 226			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 11</p> <p>Agitated."</p> <p>*On 11/8/15, "Res began whimpering while laying in bed. Was anxious and prn [as needed] Ativan [antianxiety medication] & [and] Zypresa [Zyprexa, antipsychotic] given. See emar [electronic medication administration record]. Res was quiet after meds [medications] were given."</p> <p>*There were no other follow-up nurses notes or behavior notes from the 11/7/15 incident.</p> <p>Random observations on 11/17/15 through 11/18/15 of resident 9 revealed he:</p> <p>*Utilized a wheelchair to move around the facility.</p> <p>*Could propel the wheelchair himself or had staff assistance at times.</p> <p>*Had a gait belt secured around his waist to around the back of the wheelchair.</p> <p>-The buckle of the belt was in the back of the wheelchair.</p> <p>*Sat in the hallway by the nurse's station in his wheelchair at times.</p> <p>Review of resident 9's 9/1/15 care plan revealed:</p> <p>*Specific physical and verbal behaviors were not mentioned.</p> <p>*There were no specific interventions listed to help with physical or verbal behaviors.</p> <p>*The 11/7/15 event of him flipping another resident over in the wheelchair was not mentioned.</p> <p>*There were no revisions or updates to his care plan following the 11/7/15 event.</p> <p>Review of the provider's 11/9/15 twenty-four hour Event Report to the SD DOH revealed:</p> <p>*On 11/7/15, "Confused resident [name] tipped over another resident [name] in her wheelchair. ([Name] is also confused.) Incident witnessed by a 3rd resident [name] who is oriented X [times] 3.</p>	F 226			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 12</p> <p>No signs of injury noted to [name]. [Name] was agitated at time of incident. Staff have been dealing with increased episodes of agitation from [name]. This is the first time he has attempted to harm another resident."</p> <p>*The physician, family, and administration had been notified of the event on 11/7/15.</p> <p>*There was no mention of an investigation into the cause of his behavior on 11/7/15.</p> <p>*There was no mention of what they implemented to prevent this type of behavior from happening again.</p> <p>Interview on 11/18/15 at 8:10 a.m. with registered nurse K regarding resident 9 revealed:</p> <p>*She did not feel he intentionally tried to hurt the other resident on 11/7/15.</p> <p>*He had no history of behaviors towards other residents.</p> <p>*Recently he had an overall decline in his mental and physical status.</p> <p>*His behaviors usually included anxiety and yelling.</p> <p>*He had been on medications for his anxiety and behaviors.</p> <p>-That medication had been changed recently to try and decrease his behaviors.</p> <p>*After the 11/7/15 event they had tried to watch him closer when he was around other residents, but that was not specifically documented.</p> <p>*They would not have wanted him to hurt any other residents.</p> <p>Interview and record review on 11/18/15 at 10:20 a.m. with the DON regarding resident 9 revealed:</p> <p>*She was aware of the 11/7/15 incident where he had tipped another resident over in their wheelchair.</p> <p>-The nurse had called her right away.</p>	F 226			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	<p>Continued From page 13</p> <ul style="list-style-type: none"> -They separated him from other residents right away. *He did not have a history of behaviors directed at other residents. *She: <ul style="list-style-type: none"> -Did not feel he intentionally tried to hurt another resident. -Agreed they would not want that type of event to happen again. -Completed the investigation. --The only investigation documentation was the twenty-four hour report to the Department of Health. *She confirmed there was no evidence: <ul style="list-style-type: none"> -He had been evaluated for a medical reason such as an infection to cause a change in his behaviors. -They had monitored him closer for behaviors or what they had done to protect the other residents. -They had implemented a change in his care to prevent another incident from happening. *Medications for his behaviors had been changed as recently as 11/7/15. -Those changes had been done prior to the 11/7/15 incident. <p>Interview on 11/18/15 at 11:10 a.m. with the social services director regarding resident 9 revealed:</p> <ul style="list-style-type: none"> *He had no history of behaviors directed at other residents. *She did not feel he would intentionally hurt other residents. *They had tried to monitor him closer since that incident on 11/7/15. -She agreed there was no documentation to show they had monitored him closer. *There was no documentation a thorough investigation had been completed related to the 11/7/15 incident. 	F 226		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 14 *There had been no revisions to his care plan to address his behavior on 11/7/15, and there should have been. *His care plan did not mention specific behaviors and interventions to help with them. 5. Review of the provider's revised January 2015 Mandatory Reporting of Abuse or Neglect policy revealed: **"The facility will thoroughly investigate all alleged violations and will prevent further potential abuse while the investigation is in progress." **"If the alleged abuse involves one resident/patient to another, all personnel will be alerted to keep the two individuals apart until the conflict is resolved...for preventing further abuse." *For reporting abuse: "It is mandatory that all staff report any suspected or known abuse/neglect toward residents/patients." *For identification: "It is mandatory that all employees report the following: -A. All suspicious injuries: bruising, fractures, injuries of unknown origin." **D. How to conduct an investigation: All investigations will begin immediately...All possible witnesses will be interviewed..." **All instances will be reported in the facility as outlined in this Mandatory reportable (as outlined in state regulation) need to be reported within 24 hours to: -Department of Health. -Local Ombudsman. -Must include a follow up investigation and report within 5 working days, or 7 days, if over a weekend."	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 15</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and policy review, the provider failed to update and revise care plans for 3 of 12 sampled residents (2, 5, and 9) to reflect their current needs. Findings include:</p> <p>1. Review of resident 2's 10/8/15 care plan revealed she had been scheduled Haldol (medication used to treat mental health concerns) three times per day. There was no dose documented. Staff were to use a gait belt (device used to assist in repositioning) to prevent her from leaning forward too far in her chair.</p>	F 280	<p>1. Resident #2 care plan has been updated to reflect current care practices</p> <p>2. Unfortunately we cannot go back to earlier care plans for resident going forward care plan to prevent worsening of pressure area</p> <p>3. Resident #9 care plan has been updated to reflect current care practices.</p> <p>All nurses and nursing support staff will be re-educated to Avera Care Plan Policies. All nurses will be educated to update all resident care plans as changes in conditions occur. This will be completed by Dec. 19th, 2015.</p> <p>The DON or designee will audit 10% of resident care plans weekly X4 weeks to ensure care plans are updated by nursing to reflect current care, then monthly X2 months, then quarterly X2. Results of audits will be reported to QA monthly. The committee will then determine if further action is required.</p>	11/7/16	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 16</p> <p>Review of resident 2's medical record revealed they had reduced the Haldol medication to two times per day.</p> <p>Observation on 11/17/15 at 5:00 p.m. of resident 2 revealed she did not have a gait belt in her wheelchair to prevent her from leaning forward.</p> <p>Interview on 11/18/15 at 8:35 a.m. with registered nurse K regarding resident 2 revealed: *They have been adjusting her Haldol medication for the past few months. -She was scheduled to take it two times per day. -It had been decreased once, then brought back, and now they had reduced it again. -She could not locate the dose amounts or dates of the changes in the chart. -They had added pain medications to see if she was having pain. *They did not use the gait belt anymore as she was not leaning forward like she had been in the past. *The medication and gait belt usage had not been updated or revised on the care plan.</p> <p>Surveyor: 35121 2. Review of resident 5's 4/26/15 and 7/16/15 care plans revealed interventions were not implemented to prevent the development of a stage III pressure ulcer and an open area. Refer to F314, finding 1. Surveyor: 35237 3. Random observations on 11/17/15 through 11/18/15 of resident 9 revealed he: *Utilized a wheelchair to move around the facility. *Could propel the wheelchair himself or had staff assistance at times. *Had a gait belt secured around his waist to around the back of the wheelchair.</p>	F 280		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 17</p> <p>-The buckle of the belt was in the back of the wheelchair. *Sat in the hallway by the nurse's station at times.</p> <p>Review of resident 9's medical record revealed: *On 10/15/15 an initial restraint assessment had been completed for a seat belt restraint. -That assessment stated "res [resident] very confused and anxious. Gets very agitated [upset] with staff and yells," "feels threatened," and "safety during confusion." *His physician's orders included: -An antipsychotic (used to manage psychosis [delusion (unclear, disorganized thinking); hallucinations (hearing, seeing things that are not really there); or disordered thoughts]) medication twice a day and as needed. -An antianxiety (used to treat nervousness) medication as needed. *On 11/7/15, "res [resident] flipped another res wheelchair over with res in it." -Specific cause was listed as "Behavior, Agitated." *On 11/8/15, "Res began whimpering while laying in bed. Was anxious and prn [as needed] Ativan [antianxiety medication] & [and] Zypresa [Zyprexa, antipsychotic] given. See emar [electronic medication administration record]. Res was quiet after meds [medications] were given." *There were no other follow-up nurses notes or behavior notes from the 11/7/15 event.</p> <p>Review of resident 9's 8/29/15 Minimum Data Set (MDS) assessment revealed he: *Had short and long term memory problems and moderately impaired decision making ability. -He had disorganized thinking. *Required extensive assistance from staff to complete his ADLs.</p>	F 280			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	<p>Continued From page 18</p> <ul style="list-style-type: none"> *Did not use restraints at that time. *Had physical and verbal behaviors. -Those behaviors did not interfere with care, put him at risk for injury, or have an impact on others. *Did not wander or reject care. *Had no recent change in behaviors. <p>Review of resident 9's 9/1/15 care plan revealed:</p> <ul style="list-style-type: none"> *Restraint had not been identified as a problem area. *The gait belt being used as a seat belt when in his wheelchair was not mentioned. -The restraint had been started on 10/15/15. *His specific physical and verbal behaviors were not mentioned. *There were no specific interventions listed to help with physical or verbal behaviors. *The 11/7/15 event of him flipping another resident over in the wheelchair was not mentioned. *There were no revisions or updates to his care plan following the above 11/7/15 event. <p>4. Interview on 11/18/15 at 10:20 a.m. with the director of nursing revealed:</p> <ul style="list-style-type: none"> *Care plans should have been updated to reflect the resident's current status. *Ongoing updates and revisions should have been done by the nurses or the interdisciplinary team. *She agreed resident 9's care plan should have addressed: <ul style="list-style-type: none"> -The use of a gait belt for a restraint and interventions related to the restraint. -Specific behaviors he had and interventions to help them. -Changes implemented following the event on 11/7/15 that involved another resident. 	F 280			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 280	Continued From page 19. Interview on 11/18/15 at 11:10 a.m. with the social services director regarding care plans revealed: *Resident 9's did not address his specific behaviors or interventions to help them, and it should have. *There were no updates or changes made to resident 9's care plan following the event on 11/7/15 that involved another resident, and there should have been. *Care plans should: -Have been updated by the interdisciplinary team. -Reflected the resident's current status. Review of the provider's June 2006 Care Planning policy revealed: *"The plan of Care shall be developed from each discipline's [specific and different type of staff] assessment of the resident's strength, needs, and problems." *"The overall plan of care must be reviewed every 90 days, and updated when there is a significant change of condition and/or following hospitalization." *"Each resident shall have an individualized overall plan of care which emphasizes the care and development of the whole person."	F 280			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, record review, interview, and policy review, the provider failed to implement appropriate interventions to prevent a facility acquired stage III (full thickness loss of skin exposing bone, tendon, or muscle) pressure ulcer (an injury to the skin and underlying tissue caused by unrelieved pressure, usually over a bony area) and an open area to the scrotum (area under penis) for one of one sampled resident (5) identified at risk for developing pressure ulcers. Findings include:</p> <p>1. Review of resident 5's medical record revealed he had: *Been admitted on 4/14/15. *No pressure ulcers at the time of admission. *Diagnoses of paraplegia (unable to move the lower half of the body) and edema (build-up of fluid in body tissue). *A history of pressure ulcers that had required surgical repair. *Developed a stage II (partial thickness of tissue loss) pressure ulcer to his right gluteus (bottom) on 9/27/15. *The pressure ulcer measured 1.8 centimeters (cm) by (x) 2.8 cm x 0 cm (length, width, depth) *Been evaluated by physical therapy (PT) on 10/6/15 for the pressure ulcers. -PT documentation was unclear regarding if the pressure ulcer was unstageable (unable to determine severity) or a stage III. -The pressure ulcer on his bottom had worsened to a stage III with measurements of 7.5 cm x 2.1 cm in length and width, and had not yet healed.</p>	F 314	<p>1. The braden score and careplan for resident #5 has been updated. To assure all residents are given the proper treatment to prevent pressure ulcers from occurring, all residents' Braden scores have been reviewed, all care plans have been updated and interventions implemented for all residents with braden scores less than 18 (unless interventions are already in place). Interventions will be selected based on recommendations from the Braden Intervention Guide found in meditech computerized braden intervention.</p> <p>All nursing staff will be re-educated to pressure ulcer prevention. Nurses will be required to view and pass pressure ulcer I-learn module and will continue to complete a braden assessment on admission for all new residents. If score is 18 or less we will initiate interventions based on the Braden Guide. Any</p>	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 21</p> <p>Review of the Skin Basic Assessments for resident 5 revealed: *On 4/14/15 he did not have a pressure ulcer. *On 9/27/15 he had a stage II pressure ulcer to his right gluteal cleft (bottom crease). *On 10/12/15 he had an open area to his scrotum with measurements of 1.4 cm x 0.3 cm x 0 cm, along with the stage II pressure ulcer with measurements of 3.7 cm x 1.5 cm x 0 cm.</p> <p>Review of the following Braden Scale for Predicting Sore (ulcer) Risk assessments for resident 5 revealed: *On 4/21/15 he had scored 15 (score of 15 to 18 indicated mild risk for developing a pressure ulcer). *On 7/7/15, 9/9/15, and 9/28/15, he had scored 17. *The intervention guide included the following recommendations for someone at mild risk for the development of pressure ulcers: -Frequent turning. -Maximum remobilization (as much movement as possible). -Foam or gel cushion in wheelchair and recliner. -Protect heels. -Foot cradle (device to keep bedding off the feet). -Manage moisture. -Manage nutrition. -Manage frictions and shear (rubbing against a surface that would cause a skin injury).</p> <p>Review of the Physical Therapy notes and plan of care regarding resident 5 revealed: *No notes prior to 10/6/15. *There had been an evaluation and plan of care completed by PT on 10/6/15. -PT had identified resident 5 had pressure ulcers</p>	F 314	<p>resident that shows a moderate to high risk for skin breakdown will have a weekly skin assessment completed by an RN. All nurses will be re-educated to the Avera policies and procedure for Pressure Ulcer Prevention and care planning procedures. This education will be completed by Dec. 19th, 2015. The DON or designee will audit all new admission's braden scores and care plans weekly X4 weeks, then monthly X2, then quarterly after 3 months. <u>The QA committee will direct further action.</u></p> <p>*results of the audit will be reported to QA monthly. HG/SDDOTHEL</p>	1/7/16

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 22</p> <p>on the left buttock (all other documentation indicated the right buttock) and scrotum.</p> <p>-He had a history of skin wounds that had required surgical repair.</p> <p>-He had no sensation in the area.</p> <p>-The pressure ulcer measured 7.5 cm x 2.1 cm in length and width.</p> <p>-The therapist was to educate the resident and staff on floating heels to decrease pressure and increase wound healing.</p> <p>*On 10/8/15, 10/14/15, 10/23/15, 10/26/15, and 11/2/15 the therapist had dictated that she had "told nursing to change dressing change to daily as there was significant drainage on dressing."</p> <p>*The measurements of the pressure ulcer documented were as follows:</p> <p>-10/14/15: 4.1 cm x 2.1 cm x 1.0 cm (length, width, depth).</p> <p>-10/23/15, 10/26/15, and 11/2/15: 3.4 cm x 1.5 cm x 1.0 cm.</p> <p>-11/4/15: 4.1 cm x 2.1 cm x 1.9 cm.</p> <p>-11/12/15: 2.1 cm x 3.9 cm x 2.3 cm.</p> <p>-11/16/15: 2.1 cm x 3.9 cm x 2.3 cm.</p> <p>-No measurement documented on 11/9/15; therapist documented the wound "appeared larger than last times."</p> <p>*On 11/9/15, the therapist noted possible undermining (separation of tissue from the surface under the edge of a wound).</p> <p>*PT did not document which pressure ulcer the above information referred to.</p> <p>Review of the following registered dietician's notes regarding resident 5 revealed:</p> <p>*On 9/29/15 he:</p> <p>-Had a stage II pressure ulcer on his right gluteal area.</p> <p>-Was to receive Arginaid (supplement for wound healing) twice a day.</p>	F 314		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 23</p> <p>*On 10/29/15: -His pressure ulcer was a stage III on his right gluteal area. -He was to receive Juven (supplement for wound healing) twice a day.</p> <p>*On 11/12/15 he was to receive: -Juven twice a day. -Ensure (supplement for wound healing) added to four ounces of milk with all meals. -Fortified (food with added calories and/or protein) meals. *None of those interventions had been in place prior to the development of the pressure ulcers.</p> <p>Review of the following Minimum Data Set (MDS) assessments regarding resident 5 revealed: *On the 4/26/15 and 7/10/15 MDS assessments: -He had no pressure ulcer. -He was at risk for developing pressure ulcers. -Pressure relieving devices were being used on his bed and in his chair. *On the 10/2/15 MDS assessment: -He had a stage II pressure ulcer (location was not identified). -He was at risk for developing pressure ulcers. *Interventions in place at the time of the above MDS were: -Pressure relieving devices on his bed and in his chair. -Nutrition intervention. -Application of ointments/medications to pressure ulcer. *He required extensive assistance (staff provided weight bearing support) of two staff for changing positioning while in bed on the above MDS assessments. *He had no limitation in range of motion in his upper or lower extremities on the above MDS assessments.</p>	F 314			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 24</p> <p>-That contradicted with him having been paralyzed from the waist down.</p> <p>Review of resident 5's 4/26/15 care plan revealed he had:</p> <ul style="list-style-type: none"> *Been paralyzed from the waist down. *Used a trapeze (a hanging bar attached above a bed) and side rails on his bed to aid with positioning and movement while in bed. *Required extensive assistance with bed mobility and personal hygiene. *The potential for skin breakdown. *A pressure reducing mattress on his bed. *A pressure reducing cushion in his wheelchair. *No specific interventions for frequent turning, maximum remobilization, perineal (peri, private area) care, nutrition, or for managing frictions and shearing. <p>Review of resident 5's 10/8/15 care plan revealed:</p> <p>*The interventions listed above and the following undated additions:</p> <ul style="list-style-type: none"> -On 9/27/15 a stage II area to right gluteus (bottom). -Fortified meals. -Dressing changes as needed. -Eight ounces Juven mixed with orange juice until healed. -Extra ounce of protein at meals. -Ensure clear for juice option. *A pressure ulcer temporary care plan dated 9/27/15 included the following interventions: <ul style="list-style-type: none"> -"Keep area clean, dry, and protected." -"Apply dressing and change according to PT recommendations." -"Involve PT with dressing changes as able." -"Check [dressing] daily for placement." -PT changed dressing one to two times a week. 	F 314		

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 25</p> <p>-"Nursing to assist with [dressing] changes when PT [was] not available." -Surgeon's recommendations on 11/12/15 to be up for meals only, lay only side-to-side, and to continue cushion in wheelchair. -"Increase protein intake according to RD recommendations." -"Reposition resident frequently (minimum every 2-3 hours)." -"Administer pain medications as ordered." -"Educate res. [resident] to repo-[reposition] often, discuss off-loading [take pressure off an area], discuss protein intake." *The above interventions had not been implemented until after the development of the pressure ulcers. *No intervention for nursing to change the dressing daily per PT recommendations. *No specific interventions for managing moisture, peri care, or managing frictions and shearing.</p> <p>The medication administration records and treatment administration records were requested during the survey but were not provided. The staff were unaware how to print them from their computer system in a readable condensed format.</p> <p>Observation and interview on 11/16/15 at 4:15 p.m. with resident 5 revealed he: *Was in bed with a pillow under his right side. *Was paralyzed from the waist down. *Stated he could not reposition himself very well.</p> <p>Observation on 11/16/15 at 5:13 p.m. of resident 5 revealed he had independently driven himself in his motorized wheelchair from his room into the dining room.</p>	F 314			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 26</p> <p>Observation on 11/17/15 at 8:35 a.m. of CNA E and F during a transfer of resident 5 with a Hoyer lift (equipment to move resident using a sling from one position to another) from his wheelchair to his bed revealed he offered minimal assistance with his arms when being positioned in his bed.</p> <p>Following the initial tour, this surveyor asked nursing staff to see resident 5's pressure ulcer, but was told PT did the dressing changes. The dressing would not be changed again until PT returned that Thursday. Nursing staff only changed the dressing if it was dirty or fell off. There was no opportunity for observation of the pressure ulcer.</p> <p>Interview on 11/18/15 at 2:15 p.m. with certified nurse aid (CNA) E regarding repositioning for resident 5 revealed they did not: *Reposition him every two hours or use pillows for positioning since his admission. *They started those interventions when he returned from the hospital on 8/31/15.</p> <p>Interview on 11/18/15 at 3:30 p.m. with the director of nursing regarding resident 5 revealed: *He had more than slightly limited sensory perception (ability to feel). *His paraplegia would have been a major risk factor for developing a pressure ulcer. *He had a history of wounds that required skin flap [surgical] repair. *His history of wounds placed him at a higher risk for developing a pressure ulcer. *He would have scored at a moderate or high risk for developing a pressure ulcer on the Braden Scale. *The Braden intervention guide included the following recommendations for someone at</p>	F 314			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 27 moderate or high risk for the development of a pressure ulcer: -Frequent turning with a planned schedule. -Foam wedges or pillows for 30 degree side-to-side positioning. -Small shifts in positioning. *There was no documentation the above interventions had been put into place. *He could reposition himself with his arms. *His care plan did not properly address repositioning prior to the discovery of the new pressure ulcer on his right gluteus. *He had a colostomy (opening in the abdominal wall for collecting feces in a bag) and a catheter (tube that drains urine from the bladder into a bag). *She would have expected staff to have found the pressure ulcer earlier. *She stated the possibility of peri-care "not being done as well as it should have been," because he had a colostomy and catheter. *The nurses staged pressure ulcers. *They did not offer any training on staging pressure ulcers. *The computerized skin assessment had directions to assist with staging a pressure ulcer. *She confirmed: -He did not have a pressure ulcer when he was admitted. -He developed pressure ulcers while living at the facility. -The care plan did not have all of the proper interventions put into place when he was admitted to help prevent him from developing a pressure ulcer. -His care plan was not updated to reflect PT's recommendations for daily dressing changes. -They did not follow their policies for prevention or treatment of pressure sores.	F 314			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 28 Review of the provider's revised June 2000 Decubitus Ulcer Prevention policy revealed to do the following: **"Turn patient [resident] every 2 hours." **"Position patient with pillow or pads protecting bony prominences." **"Inspect skin for redness and report to nurse." **"If redness is present, rub around reddened areas and change turning schedule to every hour." **"Whenever possible, teach patient to change his position at regular intervals." **"Wheelchair patients may be taught to shift their weight from one buttock [side of bottom] to the other." Review of the provider's revised June 2000 Decubitus Ulcer Treatment policy revealed the nursing responsibilities were: **"Nursing care will consist of intensive application of the same measures as outlined in prevention of decubitus ulcers." **"Assessment will be done daily and PRN [as needed]."	F 314		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 29</p> <p>in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and manufacturer's instructions review, the provider failed to follow instructions for disinfecting one of one observed whirlpool tub cleaning. Findings include:</p> <p>1. Observation and interview on 11/18/15 at 9:25 a.m. with certified nurse aid (CNA) A regarding the cleaning of the whirlpool revealed she:</p>	F 441	<p>1. All bath aides have been educated to tub cleaning and disinfection practices according to the tub manufacturing guidelines. Tub cleaning and disinfection guidelines have been posted beside each tub/spa for easy reference. DON or designee will audit tub cleaning and disinfecting weekly X4 weeks, then monthly X2 months, then quarterly X2 quarters to ensure each step of cleaning and disinfecting is completed. Results of audits will be reported to the QA committee monthly and they will decide if any further action is necessary.</p>	1/7/16	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 30</p> <p>*Had added approximately one to one and one-half of an inch of disinfectant solution into the foot well of the whirlpool tub.</p> <p>*Was not aware of how much disinfectant she was supposed to have added to the whirlpool tub.</p> <p>*Had never been told how much disinfectant she was supposed to have added to the whirlpool.</p> <p>*Confirmed there was not enough disinfectant to reach the back four air jets in the whirlpool.</p> <p>*Reported she had watched a demonstration given by the whirlpool manufacturer's representative on how to clean the whirlpool at the time the whirlpool was installed.</p> <p>*Was not sure how long ago the whirlpools had been installed.</p> <p>*Had not received any further training on how to properly clean the whirlpool.</p> <p>Interview on 11/18/15 at 9:54 a.m. with CNA B regarding the appropriate amount of disinfectant that should have been added to the whirlpool when she had cleaned it revealed she:</p> <p>*Did not know how much disinfectant she was supposed to add to the whirlpool.</p> <p>*Would have added "Maybe an inch or so [of disinfectant] in the front [foot well] area of the whirlpool[]." </p> <p>*Would not have added enough disinfectant to cover the "Back jets."</p> <p>*Had not been instructed on how much disinfectant she was supposed to add to the whirlpool.</p> <p>Interview on 11/18/15 at 1:15 p.m. with the director of nursing regarding the cleaning of the whirlpool tub revealed:</p> <p>*They referred to the manufacturer's instructions as their whirlpool cleaning policy.</p> <p>*The manufacturer's instructions had directed to</p>	F 441			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 31 add one to one and one-half gallons of disinfectant solution in the foot well of the whirlpool tub. *She confirmed: -The amount of disinfectant added by CNA A did not equal one to one-half gallons of solution. -They had not followed the manufacturer's instructions for cleaning the whirlpool. Review of the 3/1/08 revised manufacturer's instructions for cleaning the Pacific Aqua-Aire Recumbent Height-Adjustable Bath System 9700 whirlpool tub revealed: **"Press and hold the Disinfectant Button #2." **"As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets." **"Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub."	F 441			
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520			

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 32</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on interview and record review, the provider failed to have an effective quality assurance (QA) program in place to identify concerns, develop action plans, and implement appropriate interventions to improve performance measures for their facility. Findings include:</p> <p>1. Review of the 11/19/14 survey results revealed the following deficiencies had been cited: F176, F221, F240, F280, F281, F314, F323, F329, F333, F371, F441, and F514.</p> <p>During the current survey the following deficiencies had been cited and/or recited (*): F221*, F226, F280*, F314*, F441*, and F520.</p> <p>Audits for restraint assessments had not been completed thoroughly and had not been addressed through the QA process. Refer to F221, finding 4.</p> <p>Interview on 11/18/15 at 3:00 p.m. with the director of nursing revealed: *They had hired a person in April 2015 to manage</p>	F 520	<p>A Quality Assurance Committee is now finalized and formed. The group will include the Medical Director, DON, QA nurse, Dietary Manager, Registered Dietician, Pharmacist, Infection control, Social Service and Activities director. The group will meet once a month. Minutes will be taken, an agenda will be followed, minutes and next agenda will be sent out to members prior to the next meeting. Will review audits from survey deficiencies, infection control trends, incidents, skin/wound, medication utilizations, policy and practice, quality measures, safety concerns. Minutes of meeting will be posted in staff area for review.</p>	1/7/16	

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

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2015
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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	Continued From page 33 the quality assurance program. *That individual had not yet gotten the program running, because they were being pulled into other areas. *She agreed the audits from the previous survey had not been addressed in QA.	F 520			

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

ORIGINAL

PRINTED: 12/04/2015
FORM APPROVED
OMB NO. 0938-0391

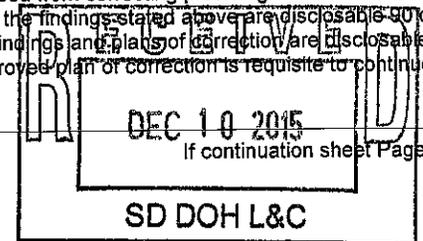
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	---	---

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 11/18/15. Avera Bormann Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE **12-9-15**

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.



DEC 10 2015
If continuation sheet Page 1 of 1
SD DOH L&C

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10660	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2015
--	---	---	--

NAME OF PROVIDER OR SUPPLIER AVERA BORMANN MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Surveyor: 18087 A license survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Nursing Facilities, requirements for nursing facilities, was conducted from 11/16/15 through 11/18/15. Avera Bormann Manor was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 32335 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 11/16/15 through 11/18/15. Avera Bormann Manor was found in compliance.	S 000		

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

TITLE

(X6) DATE

[Signature]

President/C-EO

12-9-15

STATE FORM

6899

CPIJ11

If continuation sheet 1 of 1

