

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435061	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Avera Brady Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 500 S Ohlman Mitchell, SD 57301	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, observation, policy review, and manufacturer's manual review, the provider failed to ensure a safe environment for one of one sampled resident (1), who chose not to wear the whirlpool tub chair's safety belt by not educating the resident of the risks for adverse outcomes of not using the belt, to make an informed safety decision regarding the use of that safety belt. That failure put the resident at risk for falling and potential injury. Findings include: 1. Review of the providers (02/19/26 and 02/02/26) South Dakota Department of Health (SD DOH) facility-reported incidents (FRIs) revealed two sampled residents (3,4) fell after the staff did not use an assistive device (mechanical lift and sling used to lift a person's full body to transfer to another location) or a safety device (whirlpool chair safety strap) correctly. Review of the provider's corrective actions indicated that the provider corrected the noncompliance that occurred for those two FRIs. 2. Further review of the provider's undated Bath Chair Safety staff education for direct care nursing staff revealed that All residents are to use the bath chair strap unless care planned that they refuse the bath chair strap. 3. Interview on 2/26/26 at 12:15 p.m. with assistant director of nursing (ADON) C revealed that resident 1 was the only resident who did not use the whirlpool chair safety belt. 4. Review of resident 1's electronic medical record (EMR) revealed that she was admitted to the facility on [DATE]. Her 2/9/26 care plan indicated that she was offered the whirlpool tub chair safety belt, but she may or may not use it and she had hand tremors (involuntary shaking). No documentation in the resident's EMR indicated she was assessed as not requiring the safety belt. Her 01/29/26 Brief Interview for Mental Status (BIMS) assessment score of 14, indicated her cognition was intact. The resident had a diagnoses of Parkinson's (neurodegenerative disorder causing motor symptoms like tremors, stiffness, and slow movement), diabetes (disruptions in how the body regulates blood sugar), osteoarthritis (chronic degenerative joint disease), degenerative joint disease (DJD) of the neck, and a history of L2 (second vertebra of the lower back) compression fracture and falls. No documentation indicated that resident 1 was educated on the risks and potential adverse outcomes of not using the whirlpool safety belt. 5. Interview and observation on 2/26/26 at 8:19 a.m., with certified nursing assistant (CNA) G revealed CNA G gave resident 2 a whirlpool bath with the tub chair safety belt on. She indicated that all residents wore the safety belt unless the resident's care plan indicated it was not required. 6. Interview on 2/26/26 at 12:53 p.m. with resident 1 revealed that she used the whirlpool tub chair without the safety belt. She stated, I wasn't really aware that I could fall by not using the safety belt. 7. Interview and record review on 2/26/26 at 3:00 p.m. with the director of nursing (DON) B and administrator A revealed that resident 1 chose not to wear the safety belt on the whirlpool tub chair. She indicated that resident 1 made that decision and it was put on her care plan on 8/1/25. DON B indicated that she had provided education to resident 1 about the safe use of the safety belt, but there was no documentation of that education in the resident's EMR.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 435061	Facility ID: 435061 If continuation sheet Page 1 of 2

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>DON B and Administrator A acknowledged that the manufacturer's instructions stated that all residents must always be securely safety belted when using the whirlpool tub chair. 8. Review of the provider's 10/31/2024 LTC Falls and Accidents-System Standard Policy revealed: To be proactive in preventing resident falls and accidents. 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. Hazard: elements of the resident environment that have the potential to cause injury or illnesses. 1. Staff education and involvement. A. Upon hire and annually, all staff will receive education on preventing resident falls and accidents and demonstrate competence. B. Staff will be educated about the facility's systems approach, which evaluates and analyzes hazards and risks for each individual resident based on the individual's unique status, physically and cognitively, and appropriateness for allowing some potential risks that have inherent benefits for quality of life. C. All staff will be educated about and have access to care plans which are individualized for each resident and address the potential hazards. 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 other risk/hazards within the physical environment. 9. Review of the provider's whirlpool tub manufacturer's [NAME] Bathing 6/10/2020 Transfers and Stretcher Safe Operation and Maintenance Manual revealed: Route the safety belt through the safety belt loops of the chair frame prior to placing the resident into the chair. Transfer the resident into the [NAME] Transfer using the proper nursing transfer techniques. Bring the safety belt around the resident to the buckle connector. All residents must always be securely safety belted at the waist when using any of the [NAME] Lift Systems. Ensure that the safety belt is routed through the loose buckle end as shown in the picture to the left. Pay close attention to the placement of the serrations of the buckle. If routed the opposite way, the safety belt will slip. Tighten the safety belt by pulling on the loose end of the safety belt. Warning: Failure to secure the resident properly with the safety belt could result in injury to the resident or operator.</p>