

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 04/27/2026
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, observation, interview, document review, record review, and policy review, the provider failed to protect the resident's right to quality of care according to the resident's assessment and needs for one of one sampled resident (41) whose call system cord was not working and was on a commode (portable toilet) for one hour and fifteen minutes, which was 30 minutes longer than the resident's preference, by one of one certified nursing assistant (CNA) N who did not return to resident 41's room to check on her. That failure resulted in emotional distress for the resident, who was observed by administrator (A) as being distressed, upset, and having tears in her eyes when discussing the incident. The provider failed to assess other residents' call system cords to ensure they were functioning to enable them to call for staff assistance, putting all residents who needed staff assistance with their care at risk of serious adverse outcomes such as pressure ulcers, falling, emotional distress, injury, and/or serious harm, specifically if the resident attempted to call for help with no response. Findings include: 1. Review of the SD DOH FRI revealed that on 3/5/26 at 5:15 p.m., resident 41 was heard yelling from her room by a registered nurse (RN) who was working nearby. The RN entered the room and found resident 41 sitting on the commode. The resident was upset and stated that she had been waiting for someone to answer her light [call light]. Resident 41 stated she had tried to call for help to get off the toilet at 4:45 p.m. The RN tried to activate the call light, and it would not turn on. The RN determined the call light was not activated when resident 41 had pushed the call button attached to the call system cord. She unplugged the cord from the call system box, and after plugging it back in, the call system cord began to work. Maintenance staff were notified and came at 6:30 p.m. and changed the call system cord that did not activate properly. An additional call system and call system cord were placed in resident 41's room that would be closer to the resident when she was using the commode. The provider's final report for the SD DOH FRI indicated CNA N was educated on the importance of placing an orange magnet on the outside of a resident's room door to indicate that a resident was on the toilet to ensure the resident was checked on by staff for the resident's safety, especially if the resident's room door was closed. All staff were re-educated on the use of orange magnets. Resident 41 had no signs of skin damage related to the incident. Resident 41 stated she would like to make sure her cell phone was within her reach when using the commode, so she would be able to call in the future when she needed assistance. The provider determined the resident was on the commode for approximately 30 minutes longer than she had wanted to be. 2. Observation and interview on 4/21/26 at 5:20 p.m. with resident 41 in her room revealed that there was a bariatric-size (for plus-size residents) commode next to the bathroom door. Resident 41 stated she always wore an incontinence (involuntary urine or bowel leakage) brief as she was having problems with her bowels. She indicated that she had really big and really messy BM's (bowel movements) at least three times in the last two days. Resident 41 indicated she used the commode rather than the toilet and would sit on the commode for a while. She preferred to have her door left open only a crack, she indicated she was a very private person and liked to make her own decisions. 3. An interview was attempted on 4/23/26 at 12:46 p.m. with resident 41. She declined to speak to the surveyor as she (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
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>was watching television and I don't want to be interrupted.4. Interview on 4/22/26 at 1:51 p.m. with maintenance supervisor D regarding the monitoring of the residents' call systems revealed that all call systems were checked yearly to ensure they were working.5. Interview, document review, and policy review on 4/22/26 at 3:15 p.m. with administrator A regarding the process for ensuring residents were monitored while being assisted with their toileting needs and the residents' call system revealed that the staff was to leave the call system cord within the residents' reach when the resident was assisted to the toilet or commode in their room. After the staff exited the residents' room, they were to place an orange magnet on the outside of the residents' doorframe to indicate that the resident was on the toilet or commode.Administrator A indicated that the 3/5/26 incident regarding resident 41 being left on the commode for an extended period of time, was investigated and that the root cause analysis of this incident was related to the orange magnet not being placed on the resident's door frame.Administrator A stated that on 3/6/26, she had provided education to staff members regarding the Orange Magnet Process Reminder. That documented education indicated This is a reminder that it is an important safety measure to remember to use orange magnets outside a resident's door when they are on the toilet or commode. This should be done on ALL shifts to let the nurse and your partner [co-worker] know that someone is on the toilet if they are covering for you or you are ending your shift.Administrator A stated she had visited with resident 41 about the incident on 3/5/26 and stated that resident 41 was distressed, she was upset, and had tears as she had sat on the commode for 30 minutes longer than she had wanted to be there, as her call system cord had malfunctioned and did not alert staff members she needed assistance.Administrator A reviewed the provider's 2/6/25 Abuse, Neglect, Mistreatment and Misappropriation of Resident Property policy that included, Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s), that has resulted in or may result in physical harm, pain, mental anguish, or emotional distress.Administrator A acknowledged that, based on this policy, the 3/5/26 incident of resident 41's call system cord not functioning resulted in the neglect of resident 41.Administrator A stated, We just changed out the call light computer recently, so we did a review of all call lights. She then stated, We do skin monitoring, and she [resident 41] had no [skin] issues [after the incident].6. Interview conducted on 4/23/26 at 8:00 a.m. with maintenance supervisor D regarding the residents' call system boxes revealed that, in late 2023 or sometime in 2024 (exact date uncertain), the provider began replacing the call system boxes located in resident rooms. This replacement process included ongoing updates, with several call system cords being replaced each year as part of the project.Maintenance supervisor D indicated that staff members could submit work orders for any issues related to the call light system, including instances where a device was not functioning properly or when a warning, such as a low battery alert, was triggered.Maintenance supervisor D indicated that the call light monitoring system was reviewed each morning. The system generated alerts that were displayed on workstation computers and on monitors located at the end of each hallway, which alerted the staff to issues such as missing devices or low batteries of the call system. If an alert was not promptly addressed, the system would continue to alarm every five minutes until the issue was resolved.The call system was designed to support up to three call system devices in each resident's room. Maintenance supervisor D reported that a new server for the call system was installed on 4/2/26 after an attempted update to Windows 12 rendered the system incompatible with the existing call light software. Following installation of the new server, all call light components, including each resident's call system cord to ensure they were functioning.Maintenance supervisor D stated that the call system was audited manually, once each year, usually in July, to ensure the entire system was working, including each resident's call system cord. The annual call light system audit was not completed for 2026.Regarding resident 41, maintenance supervisor D reported that on 3/5/26, he was notified by a staff member of an issue with resident 41's call system. Upon his inspection, it was determined that the zip ties securing the call system cord to the call system box had been cut. As a result, the resident pulled the cord with (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>sufficient force to bend the internal components of the call light box, resulting in the call system cord not being able to activate the call system. Maintenance supervisor D stated, I relocated the call system box to the north wall between the bathroom wall and the sink, installed a new call system box and call system cord, and adjusted the placement so the cord could reach the resident's chair without requiring excessive tension when the resident was on the commode. He further indicated that he provided education to the staff members on duty at the time regarding the incident. He did not document this education.7. Interview conducted on 4/23/26 at 10:10 a.m. with administrator A regarding the call light system revealed that the investigation into resident 41's call system not functioning on 3/5/26 determined the issue was not with the call light system itself, but with CNA not using the orange magnet to indicate resident 41 was using the commode. The orange magnet serves as a secondary check when the call light was not functioning. Administrator A indicated there was no call system delay for resident 41's room on 3/5/26 recorded by the monitoring system, as the call system cord was not operating. She further explained that the call monitoring system was capable of detecting when a call system cord is missing, but it could not detect whether the call system cord was functioning or not. Administrator A acknowledged that a non-functioning call system cord could potentially result in an accident or injury to a resident. She stated, That is why maintenance was contacted immediately upon discovery of the issue. If the cord had deactivated the box, the monitoring system would have identified it. Administrator A explained that the call system monitoring operates on an external network device and is electronically monitored through a continuous system sweep. This call light monitoring system identifies issues such as low battery levels or missing components, including call system cords that may be missing. The facility's investigation regarding resident 41's incident on 3/5/26, determined that a secondary issue with Resident 41's call light was the call system cord not working. Administrator A reported that when the nurse tested the cord several minutes after the call system cord malfunctioned, it successfully activated the call system.8. Interview and review of the provider's call system monitoring checklist, which maintenance personnel were to document any repairs to a resident's call system on 4/23/26 at 8:54 a.m. with maintenance supervisor D revealed that the checklist was not consistently utilized by all maintenance personnel, although maintenance supervisor D indicated he made efforts to keep it current. There was no documented evidence on the checklist regarding resident 41's 3/5/26 incident involving the call system cord. Maintenance supervisor D stated that some information related to the incident might be on the old [computer] server, but he was unable to access those records.9. Review of resident 41's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her 4/3/26 Brief Interview of Mental Status (BIMS) assessment score was a 13, which indicated her cognition was intact. Resident 41's diagnoses included morbid obesity (excessive weight that significantly impacts health and well-being), depression, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), chronic pain, constipation, fibromyalgia, and overactive bladder. Resident 41's 4/22/26 care plan (personalized plan that addresses a resident's care needs, goals, and interventions) indicated she required the assistance of two staff members and a sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) for her toileting needs. She used a bedside commode and liked to watch television when using it. She had bowel and bladder incontinence and wore an incontinence brief during the day and night. Resident 41 wanted to be toileted at 4 a.m. and would use her call light the rest of the time. She was at risk for falling, and her door was to be left open unless sleeping then it may be closed but I need to be checked on frequently. Staff members were to continue to educate on fall risk reinforce use of call light [system]. She had a cell phone and was able to use it independently. 10. Review of the provider's 4/8/26 Quality Assurance Performance Improvement (QAPI) meeting revealed Quality Measures included call lights. The minutes did not include how the call lights were included in the Quality Measures. Under the title of State Notifications there was an indication that resident 41 was left on commode [the staff] moved (continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>placement of [the] call light; updated care plan; question why she is sitting a long [time] . BM or bladder? The column of Action included Nursing: Assess with [resident 41's name redacted] why she is sitting for so long.11. Review of the manufacturer's Call Station Installation Guide revealed the [NAME] ES Call Station is a wireless, battery-operated, fixed-location resident call device. The alarm may be activated by a large, easy to press push-button, a pull cord, or an optional remote pushbutton. The ES call Station is also equipped with a dual-purpose Call Cancel/Check-In button. In concert with Arial software, residents can check in using the ES Call Station.The general operation of the call station was completely wireless and easy to use. The call station sends a supervision signal to the Arial server approximately every 5 minutes. The resident initiates an alarm by pressing the large blue call button, by pulling the red cord, or by pressing an optional push-button cord. The red LED would turn on and remain lit until the alarm was cancelled. A Warning listed in the manufacturer's instructions included If using optional push-button cords, inspect all connectors following every alarm. If good electrical connections are not being made, subsequent use of the push-button cord may not issue an alarm, which could lead to the injury or death of a resident.12. Review of the provider's August 2024 Call Light(s) policy revealed that a functioning call light system was required. Call system scores were calculated monthly. The goal was to answer call system lights within 10 minutes 87% of the time. If the call light was defective, the staff were to report it immediately to maintenance.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, employee education review, and policy review, the provider failed to ensure standard food safety practices were followed for one of one observed cook I who did no perform hand hygiene (washing or sanitizing hands) after she dropped and picked up a butter container lid from the floor, and coughed into her right hand and drank from her personal beverage cup while preparing and serving resident meals during the lunch meal service. Findings include: 1. Observation on 4/21/26 from 12:15 p.m. through 1:00 p.m., in the [NAME] kitchenette and dining room, revealed that cook I dropped the lid to the butter container onto the floor. She then picked the lid up and placed it on the counter next to an open bag of bagels. Cook, I did not perform hand hygiene after handling the lid that had fallen onto the floor. [NAME] I prepared a plate of food for a resident. While holding the plate in her left hand, cook I turned her head to the right and coughed into her right hand. She then continued preparing additional plates of food for residents without performing hand hygiene. There was one bottle of hand sanitizer on the counter next to the steam table line and one hand sanitizer dispenser on the North wall of the dining room. [NAME] I had her personal cup sitting on top of the food transport cart (a cart used to transfer food from the main kitchen to the residents' room). The cart was located within the [NAME] kitchenette next to the serving line. She took a drink from the cup placed it back on top of the food transport cart and without performing hand hygiene and prepared additional plates of food for the residents 2. Interview on 4/21/26 at 1:36 p.m. with assistant dietary manager (ADM) F revealed that the personal cup that belonged to cook I, which was on top of the food transport cart, was an appropriate space for cook I to place it. 3. Interview on 4/22/26 at 1:15 p.m. with cook I revealed that on 4/21/26 at 12:30 p.m., she had coughed into her right hand while holding a plate of food in her left hand she was plating for the residents during the lunch meal. [NAME] I stated she should have set the plate down and washed her hands after she coughed into her right hand. She indicated she should have started over with a clean plate to serve the resident's food on. 4. Interview on 4/22/26 at 1:20 p.m. with ADM F revealed that cook I should have set the plate of food down that she had in her left hand and washed her hands after she had coughed into her right hand. ADM F indicated they had designated spaces for the staff to keep their personal cups with lids. She stated areas where food was being prepped for the residents were not considered safe spaces for the staff beverages. 5. Interview on 4/22/26 at 1:40 p.m. with dietary manager (DM) E, revealed she expected that cook I wash her hands after she coughed into her right hand before she started serving the resident's food. DM E indicated that the top of the food transport cart was not a designated space for the staff to keep their personal cups on. She expected the staff to follow the provider's hand hygiene policy. 6. Review of [NAME] I's Continuing Education Transcript Report revealed she had received annual education on Infection Control and Prevention on 3/21/26 and Food Safety and Sanitation education on 8/2/25. 7. Review of the provider's revised May 2023 [NAME] Handwashing policy revealed the purpose was to prevent the spread of disease or other contamination of food or food utensils. The staff were to wash their hands after handling soiled dishes and utensils, sneezing and using a tissue. 8. Review of the provider's revised April 2026 [NAME] LTC-Infection Prevention Program and Authority policy revealed: a. Long Term Care (LTC) employees are given information and education in the infection prevention and control. Education will be completed as needed at the direction of the QAPI Committee. 1. Mandatory education for infection prevention and control will be held on a routine basis and may include such information as bloodborne pathogens, Tuberculosis (TB) Standard Precautions, hand hygiene, disinfection, Healthcare-Associated Infection (HAI) prevention, and proper Personal Protective Equipment (PPE) use. Documentation of annual education is retained by the Department Supervisor and/or Education Department.</p>		