| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 43A113 | A. Building<br>B. Wing | 09/04/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avera Oahe Manor | 700 E Garfield<br>Gettysburg, SD 57442 |

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) |
|---|---|
| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>(continued on next page) |

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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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to follow nursing professional standards to ensure one of one sampled resident (1) had consistent neurological checks completed and documented after the resident fell and hit her head, according to the provider's policies.Findings include:1. Review of the 8/3/25 SD DOH FRI regarding resident 1 revealed:*On 8/3/25 at 12:00 p.m. resident 1 was walking with certified nursing assistant (CNA) E to the bathroom.*CNA E let go of resident 1's gait belt (a waist strap gripped as support for safe mobility and transfers) to turn on the bathroom light.*Resident 1 lost her balance, fell to the floor, and hit her head on the floor.*Resident 1 was assessed by licensed practical nurse (LPN) F, who did not identify any injuries at that time.*Resident 1 was taken to the emergency room by her husband, who was present at the time of the fall. *While in the emergency department resident 1's husband declined a CT scan (imaging test that uses x-rays of cross sections of the body) of resident 1's head.2. Review of resident 1's electronic medical record (EMR) revealed:*She was admitted on [DATE].*Her 8/7/25 Brief Interview of Mental Status (BIMS) assessment score was 13, which indicated her cognition was intact.*Her diagnoses included Parkinson's (a disorder of the central nervous system that affects movement, often including tremors), weakness, dizziness on standing, and loss of balance.*Review of her admission care plan revealed on 8/1/25 an intervention was added to her care plan that indicated resident 1, transfers and ambulates with staff assistance x1 [times one], a walker and [the use of a] gait belt.*Resident 1's 8/1/25 fall risk assessment, had a score of 2 which indicated she required Standard fall precautions.*Resident 1 was admitted to the emergency room on 8/3/25 at 1:30 p.m. and discharged from the emergency department on 8/3/25 at 2:29 p.m.*She returned to the facility on 8/3/25 at 2:30 p.m. with a diagnosis of mild dehydration (loss of body fluid caused by illness, sweating, or inadequate intake), and was advised to increase her fluid intake.3. Review of resident 1's post-fall neurological assessments (assessment of nerve function, reflexes, coordination, motor skills, sensation, and mental status) (neuros) revealed:*There were identified areas for assessment on the Neuro Check Care Assessment in resident 1's EMR which included:- Neurological--Orientation--Behavior--Speech Patter- Glasgow Coma Scale [a neurological assessment tool used to evaluate the level of consciousness after a brain injury]--Eye opening--Verbal response--Motor response--Glasgow coma scale total score- Pupil Assessment--bilateral eyes--Pupil size (mm) [millimeters]--Pupil reaction--Pupil shape- Ocular [eye] Assessment--Eye movement--Tracking on horizontal plane--Tracking on vertical plane--Able to independently open and close eyelids- Visual Acuity--Peripheral visual fields intact--Blurry Vision-Neurological Symptoms-Dizziness/vertigo-Nausea/vomiting-Headache-Movement/Strength/Sensation--bilateral lower--Movement description--Strength description--Sensation description--bilateral upper--Movement description--Strength description--Sensation description.*Resident 1's 8/3/25 12:00 p.m. neuro assessment taken immediately after the resident's fall did not have the Pupil Assessment or the Movement/Strengths/Sensation portions of the assessment completed.*Resident 1's 8/3/25 12:30 p.m. neuro assessment did not have the Glasgow Coma Scale, Pupil Assessment, Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed.*Resident 1's 8/3/25 1:00 p.m. neuro assessment did not have the Glasgow Coma Scale, Pupil Assessment, or the Movement/Strength/Sensation portions of the assessment completed. *Resident 1's next neuro assessment was completed on 8/3/25 at 5:00 p.m. and did not have the Glasgow Coma Scale, Pupil Assessment, Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed.*Resident 1's 8/3/25 9:00 p.m. neuro assessment did not have the Glasgow Coma Scale completed.*Resident 1's 8/4/25 1:04 a.m. neuro assessment did not have resident 1's orientation, the Glasgow Coma Scale, bilateral lower sensation description, or bilateral upper sensation description.*Resident 1's 8/4/25 5:00 a.m. neuro assessment did not have the Glasgow Coma Scale completed.*Resident 1's 8/5/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale completed.*Resident 1's 8/6/25 9:00 a.m. neuro assessment had every field in the neuro assessment completed.*Resident 1's 8/7/25 9:00 a.m. neuro assessment did not have the Ocular Assessment, Visual Acuity, Neurological Symptoms, or the Movement/Strength/Sensation portions of the assessment completed.*Resident 1's 8/8/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale completed.*Resident 1's 8/9/25 9:00 a.m. neuro assessment did not have the Glasgow Coma Scale |