STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A113	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Oahe Manor	700 E Garfield 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review the provider failed to ensure, the care plans were updated for one of one sampled resident (5) to reflect her current care needs, and one of one sampled resident (38) who no longer had a urinary catheter. Findings include: 1. Observation on 7/29/25 at 2:50 p.m. of resident 5 revealed: *She was sitting in a recliner with her feet elevated in the common area. *She began sitting forward and attempted to scoot forward in the recliner. *Certified nursing assistant (CNA) J asked resident 5 to wait a moment until she got resident 5’s wheelchair. *CNA J then assisted resident 5 in transferring to her wheelchair. Observation and interview on 7/30/25 at 11:28 a.m. with registered nurse (RN) G revealed: *She pushed resident 5 in her wheelchair into her room. *RN G stated resident 5 was able to walk, but she was unsteady and had a high risk for falling. *RN G assisted resident 5 to a standing position, held her hands, and provided cues for resident 5 to walk into the bathroom. *RN G stated resident 5 would attempt to stand and walk independently at times, but staff would watch her closely and walk with her. *RN G stated resident 5 was usually continent of urine but wore a liner in her underwear at night. *Resident 5 was not wearing an incontinence product at that time. Review of resident 5’s 7/30/25 care plan revealed: (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The ADLs (activities of daily living) focus area indicated, -She was incontinent two or more times a week and wore a large pull-up. -She transferred and walked in her room independently. -She used the toilet independently. *The intervention area of bowel and bladder indicated she, -Used a panty liner for bladder leakage. Review of the 7/31/25 care sheet revealed: *Resident 5 used a wheelchair. *Staff were to walk with her in the hallway when she was restless. *She did not require any incontinence products. Interview on 7/31/25 at 10:04 a.m. with CNA M revealed: *Each staff member received a resident care sheet at the beginning of their shift that included, general care needs information for each resident. *In addition to the care sheets, she referenced the residents' care plans in the computer system to determine the care assistance she needed to provide to each resident. *Resident 5 spent most of the time in her wheelchair. *She would get up and attempt to walk independently at times, but staff would monitor her closely, and would walk with her for her safety when she stood up. 2. Observation and interview on 7/29/25 at 2:52 p.m. with resident 38 revealed: *He did not have a urinary catheter. Record review of resident 38's electronic medical record revealed: *His medical orders from 6/1/25 through 7/30/25 indicated he did not have a urinary catheter order and it was discontinued on 6/12/25. *His care plan indicated he had a urinary catheter from an outside facility related to urinary incontinence. Interview on 7/30/25 at 8:53 a.m. with CNA S regarding resident 38 revealed he did not have a urinary catheter as noted on his care plan dated 6/20/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Interview on 7/31/25 at 10:04 a.m. with DON B regarding resident 38’s urinary catheter revealed: *Resident 38’s care plan did not get updated after his urinary catheter was discontinued on 6/12/25. *She stated the nurse should have updated his care plan after they had received the order to discontinue it. Interview on 7/31/25 at 2:10 p.m. with director of nursing (DON) B regarding resident care plans revealed: *She expected resident care plans to be updated anytime there was a change in a resident’s care or condition. *The nurses were able to update care plans in addition to all the management staff. *No one was currently completing audits of the care plans to ensure they were accurate. *She was aware the care plans were not up to date and some of the information in them were not up to date. *She verified there was conflicting information in resident 5’s care plan which included, -Within the bowel and bladder focus area it indicated resident 5 was to wear a pull-up for incontinence and a panty liner for urinary leakage. -Within the ADL focus the care plan indicated resident 5 had the tendency to walk without a wheelchair or walker and she was independent with ambulation in her room. -Within the bowel and bladder focus area it indicated resident 5 needed assistance with toileting, and within the ADL focus area the care plan indicated she was independent with toileting. -The care sheet indicated she did not wear any incontinence product, and staff should walk with her in the hallway when she was restless. -The care sheet did not that she primarily used a wheelchair for locomotion. 4. Interview on 7/31/25 at 10:28 a.m. with licensed practical nurse (LPN) H revealed she did not know how to update resident care plans, and she did not know how to update care plans. 5. Review of the provider’s care plan policy dated 11/2024 revealed: *” It is the philosophy of [NAME] [long term care] LTC to communicate effectively with all staff providing care for our residents. By ensuring a standardized careplan [care plan] process we are ensuring staff is getting the needed information for [the] resident’s care.” (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*”Policy Implementation: 5. iii. Only licensed professionals and designated ancillary department leaders will have access to make any changes to a resident’s plan of care. This includes but is not limited to adding or deleting interventions from the worklist and adding or editing or frequencies on said interventions.”

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, the provider failed to have a physician order for two of two sampled residents' (12 and 38) use of continuous positive airway pressure (CPAP) devices, which deliver pressurized air through a mask to keep a person's airways open. Findings include: 1. Observation and interview on 7/29/25 at 10:22 a.m. with resident 38 revealed: *He had a CPAP machine that he cleaned himself. He stated, “I am going to as them [the staff] to do it because I think it could use a women’s touch.” 2. Interview on 7/30/25 at 8:10 a.m. with director of nursing (DON) B revealed they did not have a CPAP policy. She stated they did not have a current CPAP cleaning process but they were working on one. *She stated the current CPAP machines in the facility were newer and were cleaned in self-cleaning devices. *She stated the certified nursing assistants (CNAs) had been trained on the CPAPs by the family of a previous resident, but a newly contracted travel CNA had not been trained. 3. Interview and observation on 7/30/25 at 8:49 a.m. with CNA L revealed: *She demonstrated how resident 38’s CPAP mask went into the “SoClean” automated CPAP cleaning and sanitizing machine's tank in his room after it was removed from his face. *She stated, I just hit the “on” button and it cleans and sanitizes his mask. She was not sure how often or when his CPAP device was to be cleaned. She stated the nurses cleaned the CPAPs. She stated there was one other resident with a CPAP machine. 4. Review of resident’s 12s EMR revealed her care plan indicated she used a CPAP device but there was not a medical order for that CPAP device. 5. Review of resident 38s EMR revealed his care plan indicated he used a CPAP device but there was not a medical order for the CPAP device. 6. Interview on 7/31/25 at 11:35 a.m. with certified medication aide (CMA) I revealed she had been trained how to use the CPAP devices automated cleaning system but she did not remember who trained her or when. She thought that CPAP training was part of her new staff orientation process and yearly competency reviews. 7. Interview on 7/31/25 at 11:38 a.m. with LPN H revealed she had been trained how to use the CPAP devices but could not remember who trained her or when. She thought it had been trained probably more than a year ago since she had received any CPAP training. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. Interview on 7/31/25 at 10:04 a.m. with DON B regarding what professional standard reference she used revealed: *She stated she would have used the manufacturing guidelines for new equipment or for the current CPAP devices. *She stated she she did not have a physician order policy but had a checklist process for physician orders that the nurses followed. *There were 3 lists the nurse could use for new order, admission, or return from hospital. *She agreed that CPAP was not on any of the 3 lists for a nurse to check off that a resident had that device or that the nurse had obtained a physicians order for that devices use for a resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) Facility Reported Incident (FRI), interview, record review, and policy review, the provider failed to ensure a safe environment by not having checked the coffee temperature to ensure it was within a safe temperature range before serving it to one of one sampled residents (9) who spilled her coffee and sustained a burn to her upper anterior (front) thighs.Findings include: Review of the provider's 5/21/25 SD DOH FRI report revealed that resident 9 had spilled her coffee in her lap at a meal on 5/16/25. Findings include:1. Resident 9 had picked up her cup from the table and it caught on her meal container, tipping the coffee into her lap. She wheeled herself out of the dining room. One of her tablemates notified the activities director (who is also a CNA) who had been in the dining room, and found resident 9 attempting to enter the lobby restroom and immediately assisted her in getting the wet clothing away from her skin. The resident suffered burning and blistering to her upper anterior (front) thighs. 2. Review of DON B's notes regarding the incident revealed that the coffee maker tank was set to a temp of 180 degrees and the staff had checked the coffee temperature and it was 168 degrees. 3. Interview on 7/29/25 at 8:37 a.m. with food service worker II (FSW II) R revealed that his position held the primary responsibility for filling the coffee carafes. He had not been instructed to take the temperatures of hot beverages or on what a safe serving temperature would be. He stated that after the 5/16/25 burn from hot coffee, they left the coffee carafe open in the kitchen for a few minutes in order to cool the coffee, and then they got a new coffee machine. They did not check the temperature of the coffee carafe after leaving it open. *Interview on 7/29/25 at 10:21 a.m. with resident 9 revealed that she burned her legs when she spilled her coffee in her lap. She said it was painful at the time but it healed up quickly. She stated that it was an accident, and anyone could spill their coffee. She thought there had been too much fussing about it and she had been embarrassed by it. *Interview on 7/29/25 at 12:00 p.m. with FSW II Q revealed her FSW II position was responsible for delivering meals to residents in the dining room but was not responsible for serving hot beverages. She had never checked the temperature of the hot beverages and did not think it was a part of the provider's regular food temperature monitoring and recording process. *Interview on 7/29/25 at 2:40 p.m. with certified dietary manager (CDM) P revealed that they had not taken the temperatures of hot beverages (coffee, hot water, hot chocolate) before serving them to the residents. The coffee machine supplier had installed a low temp kit on the coffee maker on 5/20/25 that was to limit the coffee temperature. They checked and recorded the temperature of the coffee from 5/17/25 to 6/7/25. Those temperatures ranged from temperature ranging from 145 to 156 degrees Fahrenheit (F). A new coffeemaker was installed on 6/24/25 with software-controlled temperatures that was to ensure that coffee and hot water could not dispense out of the machine if it was over 160 degrees F. They had not taken any temperatures of the coffee since that new machine was installed. *Interview on 7/31/25 at 1:30 p.m. with CDM P revealed that she was not aware that director of nursing (DON) B's notes of the above incident's investigation stated that the coffee dispenser tank was set at 180 degrees F and that dietary staff had temped the coffee at 168 degrees F. She did not know who might have provided those temperatures to the DON. She stated that she had instructed the staff to check the coffee temperature to ensure it had cooled to 150 degrees F before serving. She thought a safe temperature for serving hot beverages was be 160 degrees F. *Interview on 7/31/25 at 2:00 pm. with DON B revealed she thought the 180 degrees F coffee temperature in her notes had come from the coffee machine supplier. She could not identify who had temped the coffee at 168 degrees F. *Review of resident 9's electronic medical record (EMR) revealed that she was admitted on [DATE] with a primary diagnosis of dementia. Her Brief Interview for Mental Status (BIMS) assessment score was 7 which indicated she had severe cognitive impairment. *Her 3/13/25 hot liquid risk screening indicated no safety risk factors related to hot liquids. On 5/16/25, nurse practitioner (NP) A ordered Silvadene cream and dressings to the burn site. Resident 9's family member was notified of the incident and requested that she have a burn wound consultation. An e-care wound consultation (visit with a medical provider through the use of live video) was completed with no changes to treatment recommended. Wound inspection of resident 9 on 5/23/25 indicated that skin area remained red, measured 8.5 cm x 3.5 cm, and was dry. It required no further treatment. *Review of the provider's 10/31/24 LTC Falls and Accidents Policy revealed that staff will ongoingly assess the physical environment with regard to potential hazards, including access to.hot liquids and any deficiencies in the safety of the physical environment will be immediately addressed. *Review of the provider's 5/22/24 LTC

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on Payroll Based Journal (PBJ) reports review, interview, posted nurse schedule review, and staff timecard review, the provider failed to ensure a registered nurse (RN) had been scheduled for eight consecutive hours of coverage for ten days in quarter four (Q4) (July 1 through September 30) of fiscal year 2024, and for seven days in quarter one (Q1) (October 1 through December 31) of fiscal year 2025.Findings include: 1.Interview on 7/29/25 at 8:48 a.m. with director of nursing (DON) B during the entrance conference revealed she thought the provider had a registered nurse (RN) staffing waiver in place that exempted them from the requirement of having an RN in the facility for eight consecutive hours seven days a week.2. Review of the provider's RN waiver application revealed:*The provider had an RN waiver in place that required to have been reapproved by 7/10/24.*The provider sent an email to the South Dakota Department of Health (SD DOH) to reapply for the RN waiver on 5/16/25.*On 6/5/25 the SD DOH replied to the provider's application with direction from the Center for Medicare and Medicaid Services (CMS) to, wait on the waiver review and approval until after the facility's next recertification survey.3. Review of the provider's nurse staffing schedule for 7/20/25 through 8/9/25 revealed there was no RN scheduled on 7/26/25.4. Review of the RN staff timecards for Q4 fiscal year 2024 and Q1 fiscal year 2025 revealed:*RN coverage for eight consecutive hours could not be verified for 7/19/24, 7/20/24, 7/21/24, 7/27/24, 8/16/24, 8/17/24, 9/7/24, 9/8/24, 9/28/24, and 9/29/24 in Q4 of fiscal year 2024.*RN coverage for eight consecutive hours could not be verified for 10/19/24, 10/27/25, 11/10/25, 11/28/25, 12/21/25, 12/22/25, and 12/23/25 in Q1 of fiscal year 2025.5. Interview on 7/30/25 at 8:11 a.m. with DON B revealed the provider did not have a staffing policy.6. Interview on 7/31/25 at 9:00 a.m. with administrator A and DON B revealed:*Administrator A was responsible for submitting the application to the SD DOH for the RN staffing waiver request.*Administrator A was not aware the RN staffing waiver had been due for renewal on 7/10/24.*Administrator A realized there was a lapse in the RN staffing waiver in May 2025, when she submitted the letter to renew the waiver.*Even after the lapse in the waiver was identified Administrator A, DON B stated she was not aware an RN needed to be in the facility for eight consecutive hours seven days per week.*DON B verified there were days in Q4 fiscal year 2024, and Q1 fiscal year 2025, that there was no RN in the facility for eight consecutive hours.*She stated there were days in the provider's current schedule that did not have an RN scheduled for eight consecutive hours.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Number of residents sampled:Number of residents cited:Based on observation, interview, and policy review the provider failed to follow infection control practices to ensure:*Enhanced barrier precautions (EBP) (glove and gown use when providing contact care) and contact precautions (gown and gloves must be worn when entering a resident's room to prevent the spread of an identified organism) were properly followed for two of two sampled residents (3 and 26).*The sit-to-stand lift (a mechanical lift used to assist from a seated to a standing position) slings were not shared or properly disinfected between residents (4 and 17) use.Findings include: 1. Observation on 7/29/25 at 9:38 a.m. of resident 3's room revealed:*A sign on the outside of his door indicated the need for contact precautions.*Personal Protective Equipment (PPE) was hanging on the door across the hall from resident 3's room.Review of resident 3's electronic medical record (EMR) revealed:*He had a left knee abscess that was drained on 1/27/25.-The culture obtained during the abscess being drained was positive for methicillin-resistant staphylococcus aureus (MRSA) (a contagious antibiotic-resistant infection).*He had a 4/3/25 physician order for a dressing change to an open wound on his left knee.*His 7/30/25 care plan indicated he was on contact precautions due to an open wound on his left knee that had been cultured positive for MRSA on 1/27/25.Observation and interview on 7/29/25 at 10:38 a.m. outside resident 3's with certified nursing assistant (CNA) J revealed:*CNA J exited resident 3's room with the sit-to-stand lift and placed the lift in the hallway without disinfecting the lift.*She had a gown and gloves on when she exited the room.*She walked across the hallway to the tub room and removed and discarded her gown and gloves.*She applied another pair of gloves without performing hand hygiene (handwashing).*She pushed resident 3's wheelchair into the hallway from the tub room.*CNA J then cleaned the sit-to-stand lift with a disinfectant wipe.*Resident 3 was seated in his recliner in his room.*CNA J stated resident 3 was on contact precautions because he had a wound on his knee that had previously tested positive for MRSA.Observation on 7/29/25 at 11:08 a.m. of housekeeper N in resident 3's room revealed:*She was mopping resident 3's room floor.*She was not wearing a gown or gloves, which would have been required for a resident who was on contact precautions when she entered the resident room. Interview on 7/31/25 at 1:30 p.m. with housekeeper N revealed:*The cleaning of a resident's room consisted of wiping down all the surfaces in the room, cleaning the toilet, and mopping the floor daily.*A deep cleaning of each resident's room, which included dusting and cleaning the registers was completed weekly.2. Observation on 7/29/25 at 9:38 a.m. of resident 26's room revealed, there was a green square posted on the door frame at the entrance to her room, and PPE was hanging on the back of her room door.Interview on 7/29/25 at 10:44 a.m. with CNA J revealed:*The green square on the door frame indicated the resident was on enhanced barrier precautions (EBP).*Resident 26 was on EBP for a history of MRSA.*Resident 26 did not have an open wound.3. Observation on 7/29/25 at 9:44 a.m. in the Haven secured dementia unit's common area revealed, several wheelchairs were lined up against the wall. Four of those wheelchairs had a sit-to-stand lift sling draped over the back of the wheelchair.Observation on 7/30/25 at 11:42 a.m. in the Haven common area revealed:*There was a sling draped over the sit-to-stand mechanical lift.*Registered nurse (RN) G and CNA K used a second sit-to-stand lift sling to assist resident 17 from the recliner to his wheelchair.*CNA K then placed that sit-to-stand sling on top of the other sling that was draped over the mechanical lift.*She wiped the bars on the sit-to-stand that the resident holds on to and the arms that support the lift sling with a disinfectant wipe but did not clean any other surfaces of the lift or change the lift sling.*The sit-to-stand sling was made of cloth material, which would not maintain the wet contact time required with the use of disinfectant wipes to ensure the sling was disinfected between each resident use.*CNA K then used the lift sling used for resident 17 for assisting resident 4 from a recliner to his wheelchair with the sit-to-stand lift.*CNA K then draped the sit-to-stand lift sling back over the lift.*CNA K wiped the bars on the sit-to-stand that the resident holds on to and the arms that support the lift sling with a disinfectant wipe but did not clean any other surfaces of the lift or change the lift sling.*No hand hygiene was completed before, during, or after the above residents' transfers. 4. Interview on 7/31/15 at 10:04 a.m. with CNA M revealed:*All residents were to have their own sit-to-stand sling.*The slings were to be cleaned weekly and as needed by laundry.*The sit-to-stand lifts were to be wiped down after each resident use.*She was not aware of any resident in the Haven area who was on EBP.*She wore PPE when providing any close contact cares with resident 26.*She wore PPE when she assisted resident 3 to the bathroom or changed his clothing.5. Interview on 7/31/25 at 10:18 a.m. with RN F revealed:*All residents were to have their own sit-to-stand slings.*The sit-to-stand lift