STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A137	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avera Bormann Manor	501 North 4th Street Parkston, SD 57366

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46453 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and observation, the provider failed to ensure the safety of one of one sampled resident (47) who eloped from the facility (left without staff's knowledge) and failed to report the elopement within the required timeframe. Failure to ensure safety could have led to resident injury had he not been found. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the provider's 6/24/24 SD DOH FRI revealed: *Resident 47 was admitted to the nursing home on 6/17/24. He was previously living at the adjoining assisted living facility. *At around 5:15 p.m., director of plant operations E found resident 47 near the adjoining hospital entrance. *The resident was brought back to the nursing home. *A wander bracelet was put in place afterward. *The door alarms were functioning at the time of the incident. *The resident was not injured. *The nurse on staff that day was not aware that the incident was regarded as an elopement since the resident did not leave the campus. *All staff were reeducated about elopement and reporting requirements. The provider implemented systemic changes to ensure the deficient practice does not recur was confirmed after: (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	*Observations throughout the survey of resident 47 revealed that his wander bracelet was in place and functioning. *Interviews with staff (certified nursing assistants, registered nurses, maintenance staff, and the management team) confirmed they knew the reporting requirements for elopement and were aware of the procedures to address a resident who had eloped. *Record review confirmed staff were regularly checking for wander bracelet placement and functioning, the interventions were added to resident 47's care plan, and education was provided to all direct care staff regarding missing residents and reporting requirements. Based on the above information, non-compliance at F689 occurred on 6/17/24, and based on the provider's implemented corrective actions for the deficient practice confirmed on 6/30/24, the non-compliance is considered past non-compliance.