STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Avera Health	**129 E CLAY ST , IRENE, South Dakota, 57037**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/29/25 through 12/31/25. Sunset Manor Avera Health was found not in compliance with the following requirements: F641, F678, F732, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/29/25 through 12/31/25. The area surveyed involved a resident with a documented Do Not Resuscitate (DNR) order who received cardiopulmonary resuscitation (CPR). Sunset Manor Avera Health was found not in compliance with the following requirement: F678.	F0000		
F0641 SS = E	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	F641 Addendum - Corrected to Individual: Resident #2's annual comprehensive MDS assessment was modified and signed by MDS Coordinator C on 1/23/26 to be coded as a YES on item A1500 to indicate resident #2's Level II PASRR status. Resident #6's medical record was reviewed and accuracy of the MDS was verified. Resident #9's medical record was reviewed and accuracy of the MDS was verified.Resident #34's annual comprehensive MDS assessment was modified and signed by MDS Coordinator C on 1/23/26 to be coded as a YES on item A1500 to indicate resident #34's Level II PASRR status. Resident #39's annual comprehensive MDS assessment was modified and signed by MDS Coordinator C on 1/23/26 to be coded as YES on item A1500 to indicate resident #39's Level II PASRR status. Resident #40's medical record was reviewed and accuracy of the MDS was verified. RS 1/30/26 System Changes: Admin A, DON B, MDS Coordinator C and Social Services H all met with Emily Johnson for PASRR education on 1/20/26 and Emily has subsequently assisted Social Services H to ensure we have a resident listing with the correct PASRR Levels listed. (Continued on next page)	2/4/26

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 reverse for further 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
Robin R. Stockland	Administrator	1/30/26

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F0641 SS = E	Continued from page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure six of six sampled residents' (2, 6, 9, 34, 39, and 40) with a severe mental health illness Minimum Data Set, a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs, (MDS) assessments were accurately coded for the area of Pre-Admission Screening and Resident Review (PASRR). Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 10/30/23. *His diagnoses included bipolar (mental condition causing extreme shifts in mood, energy, and activity levels), and neurocognitive disorder (a group of conditions marked by the decline in mental function like memory, thinking, and reasoning) and psychotic disorder (a loss of contact with reality characterized by symptoms like delusions (false beliefs) and hallucinations (seeing, hearing, feeling things that are not true)). *He had a level I (1) PASRR completed on 9/5/25 for a potential change in condition that stated. -"Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation."	F0641	(Continued from page 1) Sunset Manor's PASRR Policy will be updated by 2/4/26 to include the education and educational material provided by Emily Johnson on 1/20/26 and the proper procedure on how to indicate the correct PASRR Level on any future annual comprehensive MDS assessments and any sig change MDSs. Monitoring: Audits will be completed by Social Services H, DON B, Admin A or designee weekly x 4 weeks, then every other week x 2 months, followed by monthly x 3 months to audit proper completion of item A1500 on all sig change and all annual comprehensive MDS assessments in ensure proper documentation of PASRR Levels. All results will be reported to monthly QAPI meetings by Social Services H, DON B, Admin A or designee.	

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F0641 SS = E	Continued from page 2 -"The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?'" *There was Level II PASRR in resident 2's EMR dated 1/18/23. *Item A1500 of his 10/9/25 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" 2. Review of resident 6's EMR revealed: *She was admitted on 4/22/24. *Her diagnoses included depression, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and psychotic disorder. *She had a level I PASRR completed on 9/5/25 for a potential change in condition that stated. -"Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation." -"The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?'" *There was no Level II PASRR in resident 6's EMR. *Item A1500 of his 5/8/25 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" 3. Review of resident 9's EMR revealed:	F0641		

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F0641 SS = E	Continued from page 3 *She was admitted on 2/15/23. *Her diagnoses included depression, anxiety disorder, psychotic disorder, and schizophrenia (a severe brain disorder causing distorted reality perception, featuring hallucinations, delusions, disorganized thinking, and reduced emotional expression). *She had a level I PASRR completed on 7/24/25 for a potential change in condition that stated. -"Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation." -"The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?'" *There was a Level II PASRR in resident 9's EMR dated 11/14/18. *Item A1500 of his 2/28/25 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" 4. Review of resident 34's EMR revealed: *She was admitted on 11/3/20. *Her diagnoses included depression, anxiety disorder, and bipolar disorder. *There was a Level II PASRR in resident 34's EMR dated 7/14/23. *Item A1500 in of his 7/6/25 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?"	F0641		

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F0641 SS = E	Continued from page 4 5. Review of resident 40's EMR revealed: *She was admitted on 2/27/24. *Her diagnoses included depression, anxiety disorder, and psychotic disorder. *She had a level I PASRR completed on 9/5/25 for a potential change in condition that stated. -"Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation." -"The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?'" *There was a Level II PASRR in resident 40's EMR dated 3/11/25. *Item A1500 of his 3/31/25 comprehensive MDS assessment was coded "No" to the question "Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?" 6. Review of resident 39's EMR revealed: *He was admitted on 10/3/24. *He had diagnoses of Parkinson's disease (a brain disorder that slowly worsens over time leading to symptoms of shaking, stiffness, slow walking, balance issues, and potential problems with sleep, mood and thinking), dementia (a group of symptoms affecting memory, thinking and social abilities), major depressive disorder (a serious mood disorder where intense sadness, hopelessness, and loss of interest in life for at least two weeks, making it hard to do daily things) (MDD), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *He had current physicians orders for clozapine (an	F0641		

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F0641 SS = E	Continued from page 5 antipsychotic [a medication that alters the activity of neurotransmitters in the brain to reduce symptoms of psychosis (a state of losing touch with reality) and duloxetine (an antidepressant medication). *His 3/4/25 and 6/11/25 PASRR level I screen outcomes indicated he had a positive level I, and no status change. -His PASRR conditions were serious mental illness. -His 6/11/25 PASRR outcome explanation stated: -" Your Level 1 Screen was submitted for a potential status change. It shows you have evidence of a serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation. If your needs change, a new Level 1 screen should be submitted by your health care provider. Unless your needs change, your PARR Level II Summary of Findings remains valid during your stay at the nursing facility and should transfer with you if you move to a different nursing facility. You require no further Level 1 screening unless you experience a significant change in serious mental illness or IDD treatment needs. " -"Since this evaluation has determined that you have a PASRR condition, if you admit to a Medicaid-certified nursing facility...the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for questions A1500 on the Minimum Data Set, "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition?" Also, your specific PASRR condition(s) should be checked in question A1510, Level II 'Preadmission Screening and Resident Review (PASRR) Conditions.'" -His 10/9/25 comprehensive MDS assessment, question A1500, "Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition?" was marked "No". -Item A1500 was coded "No" on his 10/25/24 and11/21/24 comprehensive MDS assessments. 7. Interview on 12/31/25 at 1:18 p.m. with social	F0641		

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F0641 SS = E	Continued from page 6 service designee (SSD) H revealed she: *Had just started in the SSD position in August. *Was responsible for submitting the PASRR screens to Maximus (the state contracted agency responsible for reviewing, making determinations, and recommendations related to residents' PASRR screening results). *Submitted PASRR screens to Maximus for review on any resident with a mental health medication change or a new mental health diagnosis for evaluation. *Did not enter the PASRR information into the residents' MDS assessments. *Verified residents 2, 6, 9. 34, 39, and 40 had level II PASRRs according to the information provided by Maximus. *Agreed that if a resident's level II PASRR was not present in their EMR she would not be able to determine if the PASRR II recommended services were being provided. 8. Interview on 12/31/25 at 1:42 p.m. with administrator A revealed: *Registered nurse (RN)/MDS coordinator C was responsible for coding the PASRR information in the residents' MDS assessments. -RN/MDS coordinator C was not available for an interview during the survey. *Administrator A expected the residents' MDS assessments to be coded accurately. 9. A review of the provider's 1/2025 LTC Resident-Assessment-Instrument (RAI)-System Standard policy regarding MDS completion revealed: *"All persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to its accuracy." *"The Assessment Coordinator is responsible for electronically transmitting encoded, accurate, and complete MDS data to the CMS [Center for Medicare and Medicaid Services]...."	F0641		
F0678 ~~SS = D~~	Cardio-Pulmonary Resuscitation (CPR)	F0678		2/4/26

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F0678 SS = D	Continued from page 7 CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), record review, interview, and policy review, the provider failed to ensure staff followed a resident's documented do not resuscitate (DNR) code status wishes for one of one closed record sampled resident (52) when discovered with no pulse or respirations by staff and was then provided cardiopulmonary resuscitation (CPR) without first verifying the resident's code status. Findings include: 1. Review of the provider's 7/15/25 SD DOH FRI revealed: *On 7/15/25 at 5:20 a.m. a nurse obtained resident 52's vitals which were stable, and her blood sugar was reading high both times it was checked and then assisted resident 52 (who had agreed to go to the hospital) to the restroom. *The nurse called the on-call provider to report on resident 52's condition and to receive orders to administer insulin and Zofran (medication for nausea). *A second nurse went to resident 52's room and found her slumped over on the toilet and heard a gurgling noise. The resident's vitals were not able to be obtained. Resident 52 was transferred to the floor where staff started CPR, and applied an AED (automated external defibrillator). *Three nurses performed chest compressions on resident 52. *The director of nursing (DON) B arrived during resuscitation efforts in resident 52's room and informed staff to stop CPR due to the resident having no breath sounds or an apical pulse. The resident's time of death was reported as 7:05 a.m. on 7/15/25 at the facility.	F0678	F678 Addendum - Corrected to individuals/System: All CNAs and nurses were re-educated on proper code status procedures at the mandatory CNA & nurse's meetings on 1/28/26 and for staff not able to attend they will complete the education by 2/4/26. Education also included advance directives, CPR and Code status. RS 1/30/26 Corrective Action: Sunset Manor will begin having mock codes 2 times per year. All CNAs and Nurses are already required to be CPR certified, and this will continue. If any staff are unable to attend these mandatory meetings they will be required to receive the education which includes advance directives, CPR and Code status by their next shift or no later than 2/4/26. Red stickers for DNR or green stickers for Full Code will be added to all resident name plates outside of their rooms to assist staff with quickly identifying Code Status. Monitoring: Audits will be completed by DON, ADON or designee to ensure staff are carrying hall sheets which is where resident code status is indicated. Audits will be done weekly x 4 weeks, every other week x 2 months and monthly x 3 months. Audits will also be completed by DON, ADON or designee to ensure accuracy of hall sheets and stickers outside of resident rooms. Audits will be done weekly x 4 weeks, every other week x 2 months and monthly x 3 months. All audit results will be reported at monthly QAPI meetings by DON, ADON or designee.	2/4/26

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F0678 SS = D	Continued from page 8 2. Review of resident 52's closed electronic medical record (EMR) revealed: *She was admitted to the facility on 9/18/24. *She had an advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) signed by her legal representative and physician on 9/18/24 indicating her resuscitation code status was a DNR/DNI. *There was an active physician's order on 9/18/24 indicating she was a DNR/DNI. 3. Interview on 12/31/25 at 8:35 a.m. with DON B and administrator A about the FRI regarding resident 52 revealed: *There were three nurses (licensed practical nurse (LPN) F, registered nurse (RN) K, and LPN DD) involved in the above incident on 7/15/25. *The nurses had started CPR on resident 52, checked the code status which was a DNR/DNI, but continued performing CPR. *The nurses involved explained to DON B that they thought since they had already started CPR they were to continue until EMS had arrived. *By the time DON B had arrived and verified that resident 52 was a DNR/DNI the nurses had been performing CPR on resident 52 for about 20 minutes. *DON B and administrator A spoke with the medical director who reported that the staff should have stopped CPR once they confirmed the code status of a resident was a DNR. *On 7/15/25 DON B conducted a nurses meeting after resident 52's incident where she educated the staff on advance directives and code statuses. *She expected her staff to call for help, grab the crash cart, call a supervisor and the provider, and check the code status in the event a resident was unresponsive. *DON B did not expect the staff to recall a resident's code status and expected the staff to start CPR until they could verify the code status of the resident. *The code statuses of residents were identified in	F0678		

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F0678 SS = D	Continued from page 9 their EMR and on the hall sheets (lists residents' care needs and interventions) that the staff members were to carry with them while they worked. *They stated they had not performed any auditing or monitoring to ensure the residents' code statuses were identified or that the staff were aware of the expectations regarding their processes for providing life sustaining measures according to a resident's code status after resident 52's incident. 4. Interview on 12/31/25 at 9:45 a.m. with LPN L revealed: *She had started working at the facility in November 2025. *She had received general education regarding advance directives and code status. *She explained she would not start CPR on a resident with a DNR code status if the resident was unresponsive with no pulse or respirations. *Resident code statuses were identified in the EMR and the hall sheets. 5. Interview on 12/31/25 at 9:57 a.m. with LPN D revealed: *She started working at the facility in November 2025. *Resident code statuses were identified in the EMR and the hall sheets. *In an emergency, she would check a resident's code status before beginning CPR. *She received mandatory education about advance directives and code statuses. 6. Interview on 12/31/25 at 10:09 a.m. with certified nursing assistant (CNA) J revealed: *She had worked at the facility for about a week. *She was CPR certified. *She watched orientation training videos, but they did not provide education specifically regarding a resident's code status.	F0678		

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F0678 SS = D	Continued from page 10 *Resident's code statuses were identified in the EMR and the hall sheets. 7. DON B was unable to provide signed education documentation of the nursing staff to verify who attended the nurses meeting on 7/15/25 after resident 52's 7/15/26 incident. 8. Review of the provider's new hire orientation and annual education for staff revealed they provided education on advance directives and resident code statuses. 9. Review of the provider's reviewed 10/2025 LTC Code Status/Resuscitation policy revealed: *"To provide staff with accurate information in the event of cardiac and/ or respiratory arrest." *"e. A 'Medical Emergency' [a health condition or situation that needs immediate medical attention] is initiated on any resident needing emergency resuscitation due to a cardiac and/ or respiratory arrest unless there is a 'Do Not Resuscitate' order documented in the resident's electronic medical record." 10. Review of the provider's 2/14/2024 Advance Directive policy revealed: *"It is the policy of this facility will provide basic life support, including CPR – Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives. Nurses are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place."	F0678		
F0732 SS = F	Posted Nurse Staffing Information CFR(s): 483.35(l)(1)-(4) §483.35(l) Nurse Staffing Information. §483.35(l)(1) Data requirements. The facility must post the following information on a daily basis:	F0732	F732 System correction: 1:1 education was provided by DON B to night nurses on the new process and updated staffing census sheets on 1/6/26 – 1/8/26. System changes: Staffing census sheets that were effective during the night shift on 1/6/26 for 1/7/26 now reflect the number of hours versus the number of staff. (Continued on next page)	1/8/26

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F0732 SS = F	Continued from page 11 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and facility assessment review, the provider failed to post the required nursing staffing information in a location readily visible to residents, staff, and visitors that clearly reflected actual hours worked by the nursing staff from October 2025 through December 2025 daily:	F0732	(Continued from page 11) The sheets were also updated to split the hours of the CBU/ TBI nurse when they are working on both of those units during their shift. RN hours were also added to ensure that we are accounting for all RN hours in the building. All staffing census sheets will updated as necessary for any staff changes that may have occurred due to staff call-ins. All completed staffing census sheets will be kept in binders for easy access Monitoring: Audits will be completed by ADON, DON or designee to ensure that census sheets are being completed and updated adequately. Audits will be completed weekly x 4 weeks, every other week x 2 months and monthly x 3 months. All results from the audits will be reported at the monthly QAPI meetings by ADON, DON or designee.	

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F0732 SS = F	Continued from page 12 *For 46 of 92 days reviewed regarding the Traumatic Brain Injury unit (TBI). *For 24 of 92 days reviewed regarding the Challenging Behavior Unit (CBU). *For 13 of 92 days reviewed regarding the main area where residents resided (The Manor). Findings include: 1. Observation on 12/29/25 at 2:34 p.m. of the provider's posted nurse staffing hours for The Manor and the CBU revealed: *The information was posted on a bulletin board near the nurses' station in the Manor. *It included the date of 12/26/25 and resident census for The Manor and the CBU. *There were no registered nurse (RN) hours documented on those postings. 2. Observation on 12/29/25 at 3:45 p.m. in the TBI unit revealed there were no posted nurse staffing hours. 3. Observation on 12/31/25 at 9:28 a.m. of the provider's 12/31/25 posted nurse staffing hours for The Manor and the CBU revealed there were no RN hours documented for that day. 4. Review of the posted nurse staffing hours from 10/1/25 through 12/31/25 revealed there were no nurse staffing information forms for: *The Manor on 10/10/25, 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, 12/27/25, 12/28/25, and 12/29/25. *The TBI unit on 10/1/25, 10/3/25, 10/7/25, 10/11/25, 10/12/25, 10/13/25, 10/16/25, 10/17/25, 10/21/25, 10/29/25, 11/1/25, 11/2/25, 11/3/25, 11/6/25, 11/7/25, 11/11/25, 11/14/25, 11/18/25, 11/20/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, 12/2/25, 12/3/25,12/8/25, 12/10/25, 12/11/25, 12/13/25, 12/14/25, 12/15/25, 12/18/25, 12/19/25, 12/23/25, 12/24/25, 12/25/25, 12/26/25, 12/27/25, 12/28/25, and 12/29/25. *The CBU on 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25,	F0732		

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F0732 SS = F	Continued from page 13 12/10/25, 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/52, 12/27/25, 12/28/25, and 12/29/25. 5. Review of the posted nurse staffing hours from 10/1/25 through 12/31/25 revealed there were no documented RN coverage hours for 10/7/25, 10/23/25, 10/27/25, 11/12/25, 11/24/25, 11/25/25, 11/28/25, 12/3/25, 12/4/25, 12/8/25, 12/11/25, 12/13/25, 12/14/25, 12/17/25, 12/18/25, 12/22/25, 12/23/25, 12/26/25, 12/30/25, and 12/31/25. 6. Review of the provider's nurse staff schedules from 12/13/25 through 12/31/25 revealed: *On 12/13/25 RN/Minimum Data Set (MDS) coordinator C was scheduled to work, and those hours were not represented on the posted nurse staffing hours. *On 12/14/25 RN/assistant director of nursing (ADON) FF was scheduled to work, and those hours were not represented on the posted nurse staffing hours. *On 12/18/25 RN/ADON FF was scheduled to provide resident care from 8:00 a.m. until 11:30 a.m. and director of nursing (DON) B was scheduled to provide resident care from 11:30 a.m. until 6:00 p.m. due to an LPN that was identified on the nurses' schedule to have called in sick. -The posted nurse staffing hours were not updated to reflect that change. 7. Review of the posted nurse staffing forms and interview on 12/31/25 at 10:43 a.m. with LPN D on the TBI unit revealed: *The posted nurse staffing hours were posted on a bulletin board behind a desk in the unit's common area. *LPN D stated the posted nurse staffing hours were to be completed each day, but she did not know who completed them. *She did not change the information on the posted nurse staffing if there were changes in the staffing during her shift. *She verified the nurse assigned to the CBU and TBI unit shared their scheduled hours between the two units, but the TBI unit posted nurse staffing form identified the nurse was scheduled on that unit for the entire 12-hour shift, which was inaccurate.	F0732		

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F0732 SS = F	Continued from page 14 *LPN D agreed the location of the posted nurse staffing hours in the TBI unit was not readily visible for residents or visitors. 8. Interview on 12/31/25 at 1:42 p.m. with administrator A revealed: *The night shift nurse was responsible for completing the daily nurse staffing hours form for the next day according to the staff schedule and resident census and was to post them in each unit. *She expected that the posted nurse staffing hours would be updated each shift if there was a staffing change by the nurse on duty in that unit. *She expected the hours on the posted staffing to be accurate. She agreed the nurse hours documented on those forms for the TBI unit and the CBU were not accurate. 9. Interview on 12/31/25 at 3:09 p.m. with director of nursing (DON) B revealed: *The posted nurse staffing hour forms were to be completed by The Manor night shift nurse and posted on each unit. *The MDS coordinator and the DON hours were not included on the posted nurse staffing hours forms. *She verified that she and the MDS coordinator assisted with resident care needs. *She verified the MDS and DON hours were submitted as RN coverage hours in the Payroll Based Journal (PBJ) reporting system. *The posted nurse staffing hours were to be posted daily and were to be accurately reflect the hours worked by each staff member. *She agreed there were missing posted nurse staffing hour forms for all three units. *She agreed that the staff did not update the posted nurse staffing forms to represent an accurate number of hours worked for each shift. *She agreed the LPN and RN hours posted for the CBU and TBI units did not accurately represent that the nurses split scheduled 12-hour shifts between the two units. *She expected the posted nurse staffing hours to be	F0732		

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F0732 SS = F	Continued from page 15 completed accurately and posted in a location that was visible for residents, staff, and visitors. 10. Review of the provider's 4/2/25 Facility Assessment revealed: *Staffing Plan "Nursing, nutrition services and housekeeping staffing is evaluated at the beginning of each sift [shift] and adjusted as needed to meet the care needs and acuity of the resident population. See the posted nursing staffing hours for details." "CBU: Charge Nurse: 5:30a [a.m.]- 6p [6:00 p.m.], 5:30p-6a (shared with TBI)". "TBI: Charge Nurse: 5:30a [a.m.]- 6p [6:00 p.m.], 5:30p-6a (shared with CBU)". *"Support Staff: Director of Nursing: Monday thru Friday 7am [7:00 a.m.] -5p. [5:00 p.m.] MDS Coordinator, RN: Monday thru Friday 8am-4:30pm". *"At the minimum there is one RN/LPN in [the] facility at all times for 24h [24 hour] nursing coverage (8 hour RN coverage at minimum)."	F0732		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) §483.60(l) Food safety requirements. The facility must - §483.60(l)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F0812	F812 Corrected to Individuals: All dietary staff including cooks M, P & Q, along with dietary aides N & O were reeducated on all dietary sanitation issues indicated in F812. Education was completed by RD EE on 1/16/26 on Handwashing & Glove Use, Food handling/Preparation, Foodborne illness, serving/distribution, leftovers, time/temp controls, nutrition/ hydration, sanitation and food safety. System changes: DM R created and implemented a triple sink sanitizer log, a 2nd food temperature log and a sanitizer bucket log on 1/8/26. Monitoring: Audits will be completed by DM R, RD EE or designee 2 x/weekly x 1 month, 1x/weekly x 1 month, every other week x 2 months and 1x/month x 2 months. (Continued on next page)	1/16/26

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F0812 SS = E	Continued from page 16 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(l)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review the provider failed to ensure the staff followed standard food safety practices regarding: *Monitoring the food and drink temperatures prepared and served were served to residents by cook M, P and Q and dietary assistant (DA) N on one of one evening meal services and one of one lunchtime meal services. *Handwashing and glove use by DA N and O and Cooks P and Q was followed during one of one evening meal service and one of one lunch time service in the kitchen. Findings include: 1. Interview on 12/29/25 at 3:17 p.m. with resident 48 in her room revealed: *She stated the food was not prepared well. *At times the food is overcooked and at times it is cold. *She stated that there were multiple residents who did not eat their meals due to how the food was prepared and served. *She had reported her concerns to staff members but they were not the staff members who "had the authority" to do anything about her concerns. 2. Observation on 12/29/25 at 5:23 p.m. from of the residents' meal trays in the kitchen revealed the residents' drinks were pre-poured and stored on individual resident trays on an open sided cart. 3. Observation and interview with DA N on 12/29/25 at 5:32 p.m. from the dining room of the residents' during the evening meal service revealed:	F0812	(Continued from page 16) Audits that will be completed include the following; 1.Proper handwashing/glove use by dietary staff. 2.Food temperatures and 2nd food temperatures being completed properly. 3.Sanitizer Bucket and Triple Sink logs being completed properly. All audit results will be reported at monthly QAPI meetings by DMR, RD EE or designee.	

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F0812 SS = E	Continued from page 17 *With only a few resident trays left to be served, DA N was requested to measure the temperature of the milk. *DA N asked cook M how to measure the temperature of the milk. *Cook M removed a thermometer out of the sink, put hand sanitizer on the thermometer, wiped the thermometer off and gave it to dietary assistant N. *DA N measured the temperature of the milk with that thermometer and stated it was 53.6 degrees Fahrenheit (F). *When asked what the temperature of the milk was supposed to be DA N stated he would have to refer to dietary manager (DM) R. *Cook M stated the milk needed to remain between 36- and 40-degrees F for safe consumption. *DM R dumped that glass of milk out and instructed cook M to dump out all the remaining poured prepared of milk on the trays to pour new glasses of milk. 4. Observation on 12/29/25 at 5:40 p.m. of DA N in the kitchen and dining room revealed: *He handled dirty linens from the kitchen and dining room with his bare hands. *With those same bare hands, he handled three glasses with his fingers by the tops inside glasses, poured milk into those glasses and then placed them on the residents' meal trays to be served to the residents. 5. Observation on 12/30/25 at 11:07 a.m. of cook P in the kitchen revealed: *Cook P put on gloves without washing her hands. *She then picked up the blender that contained pureed foods, used those same gloved hands and a spatula to pour the pureed food into the tray to be placed in the steamer, wiped the pureed foods from the side of the container with her gloved hands, and placed the container in the steamer. *She removed and discarded her gloves, and did not wash her hands. With her bare hands she removed a container of coleslaw, and a container of ham spread from the refrigerator, put them on the counter, and entered the pantry that was attached to the kitchen. When she	F0812		

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F0812 SS = E	Continued from page 18 returned to the kitchen, she did not wash her hand and then put on a pair of gloves. *With those hands cook P poured ice into containers for the coleslaw container to be stored on, removed her gloves, did not wash her hands, and gathered thermometers and alcohol wipes to check the holding temperatures of the prepared foods. 6. Observation and interview on 12/30/25 at 11:22 a.m. of cook P as she checked the temperatures of the residents' prepared food items revealed: *She washed her hands and put on a pair of gloves. *She checked the temperatures of all of the food that were stored in the steam table. *Cook P did not take the temperature of the fries under the heat lamp or the assorted pieces of chicken in the warmer. *Cook P placed a chicken drummy from that on a resident's meal tray it was served to the resident. *Cook P was asked to take the temperature of the chicken pieces. The temperatures of the chicken drummies were 130 degrees F. *Cook P then placed all the chicken pieces back into the oven. *Cook P verified she should have checked the temperature of the chicken pieces prior to serving them to the residents. *Cook P verified the dietary staff were supposed to check the temperatures of the food items to be sure the food was cooked and stored at a safe temperature before serving the food to the residents. 7. Observation on 12/30/25 at 11:45 of cook Q revealed: *She did not perform hand hygiene and then began placing covers over the chocolate cake with whipped topping. *One of the pieces of caked tipped over and the whipped topping handed on cook Q's hand. *Cook Q tipped the cake back up with her bare hand, put a cover on the cake, and washed her hands 8. Observation on 12/30/25 at 11:52 a.m. in the kitchen	F0812		

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F0812 SS = E	Continued from page 19 during the meal service revealed: *Cook P had gloves on and retrieved a knife from the magnet on the wall. *With those same gloved hands, she held a chicken breast with one hand as she cut the chicken breast into pieces. *DM R instructed Cook P to use a fork to cut up the chicken breast. *Cook P covered the plate of chicken with an insulated cover, placed it on a resident's meal tray. *Cook P used those same gloved hands to grab a bowl from the shelf by the inside and the top of the bowl. She dished soup into that bowl and placed the bowl of soup on a resident's meal tray. *At 12:00 p.m. pre-poured cold drinks were removed from the refrigerator, placed on the individual resident trays, and stored on an open sided cart in the kitchen. *Cook P again plated a resident's meal that included chicken breast with the same process observed above and she prepared two more meal trays with those same gloves on. *Cook P touched the resident's plated mashed potatoes with those same gloved hands while cutting another chicken breast to serve to the resident. *With those same gloved hands Cook P touched and moved potato wedges to the side of to serve to the resident and hen touched a chicken breast while she cut it into pieces. *With those same gloved hands cook P moved a chicken piece to the side of a resident's plate to make room other food items. *With those same gloved hands Cook P picked up a piece of breaded chicken pulled it into pieces and served it to the resident. She continued to touch several other food items with those same gloved hands as she plated the residents' meals. 9. Observation and interview on 12/30/25 at 12:25 p.m. of lunch meal service with cook Q revealed: *Cook Q was asked to take the temperature of the last milk being served.	F0812		

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F0812 SS = E	Continued from page 20 *Cook Q stated the milk was 50 degrees F and dumped out the milk and poured new glasses of milk to serve to the residents. 10. Interview on 12/31/25 at 9:33 a.m. with DA O revealed: *Gloves were to be worn when handling ready to eat foods. *Hands should be washed entering or leaving the kitchen and before putting on gloves and after taking gloves off. 11. Observation on 12/31/25 at 9:51 a.m. of DA O in the kitchen revealed: *With gloved hands DA O prepared lettuce salads, handled dirty dishes, and put sandwich meat into a plastic container. *She removed those gloves, did not wash her hands, and put cheese and lettuce salads into the refrigerator. *With her unwashed bare hands, she handled dirty dishes, picked up trash off the floor, and then wiped off the counter where she had prepared food. 12. Review of the provider's October 2025 through December 2025s food temperature log revealed: *There were no documented temperatures of the prepared food items that were to be plated and served to the residents. *There were no documented temperatures of hot or cold drinks to be served to the residents. 13. Interview on 12/31/25 at 2:40 p.m. with DM R revealed: *She expected gloves to be worn by the staff when handling ready to eat foods. *Gloves should be removed and discarded when they were visibly soiled, and hands should be washed before putting on gloves and after removing gloves. *She expected staff to use clean gloves or clean hands to prepare and serve resident's meals. *Staff were to wash their hands when they entered the kitchen, and after using the bathroom.	F0812		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0812 SS = E	Continued from page 21 *The food temperatures were to be checked when it was done cooking ensure it was completely cooked and then prior to serving to ensure it was held at a safe temperature. *She verified staff only documented the cooking temperatures of food and not the holding temperatures. *She verified she could not be sure the holding food temperatures had been taken or within the safe holding temperature ranges if they were not documented. *She verified that the temperatures of the milk and chicken on 12/29/25 and 12/30/25 did not meet the safe temperature ranges. 14. Review of the provider's 2023 Food Temperatures policy revealed: **"The temperatures of all food items will be taken and properly recorded prior to the service of each meal. 1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 [degrees] F." **"Hot food items may not fall below 135 [degrees] F after cooking, unless it is an item which is to be rapidly cooled to below 41 [degrees]." **"Temperatures should be taken periodically to assure hot foods stay above 135 [degrees] F and cold foods stay below 41 [degrees] F during the holding and plating process and until food leaves the service area." **"Food preparation areas will follow these methods: a. Hold foods at or below 41 [degrees] F for cold foods and at or above 135 [degrees] F for hot food (to keep out of the temperature danger zone." Review of the provider's 2023 Bare Hand Contact with Food and Use of Plastic Gloves policy revealed: **"Single use gloves or other barriers will be used when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Barehand contact with food is prohibited." **"Staff will use clean barriers such as single use gloves, tongs, deli paper and spatulas when handling foods."	F0812		

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F0812 SS = E	Continued from page 22 *"Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only on task such as working with ready-to-eat (RTE) food or with raw animal food, used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation." *"Hands are to be washed when entering the kitchen and before putting on single use gloves (before beginning work with food) and after removing single use gloves." *"Clean gloves are to be used when: a. Handling ready-to-eat foods... f. Anytime hands would otherwise touch food directly." *"Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed and hands must be washed: ...During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks... After engaging in other activities that may possibly contaminate the hands with bodily fluids... Any time a contaminated surface is touched." *"Hands should be washed after removing gloves."	F0812		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	F880 Addendum - Individual Correction: CNA T was re-educated with 1:1 education on EBP, Hand Hygiene & Glove Use, cleaning of lifts and proper use of slings on 1/27/26. CNA W had 1:1 re-education on the same topics on 1/28/26 and CNA X will have 1:1 re-education of the same topics on 1/31/26. We were unable to re-educate CNAs BB & CC as they no longer work/pick-up shifts at our facility. CNAs AA, Y & Z are only PRN temp agency staff and have no shifts scheduled but will be educated on their next shift if they pick up any more shifts in our facility. RS 1/30/26 System Correction: Re-education was provided to all staff across all departments on 1/28/26 at All Staff Meeting, CNA and Nursing Meetings. Any staff not able to attend these meetings will complete the education by 2/4/26. Education includes; EBP, Hand Hygiene & Glove Use, cleaning of lifts and proper use of slings. This education will continue to be provided to all new staff with orientation and on an annual basis. (Continued on next page)	2/4/26

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F0880 SS = E	Continued from page 23 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	(Continued from page 23) Monitoring: Audits will be completed by IP, DON, ADON or designee, weekly x 4 weeks, every other week x 2 months and monthly x 3 months across varying shifts. Audits that will be completed are as follows: 1.Stand aid and Hoyer lifts across varying nursing shifts, weekly x 4 weeks, every other week x 2 months, monthly x 3 months. 2.Hand hygiene and EBP across varying shifts and departments, 2x week for 1 month, weekly x 2 months, monthly x 3 months. All audit results will be reported at the monthly QAPI meetings by the IP, DON, ADON or designee.	

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F0880 SS = E	Continued from page 24 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed regarding: *Cleaning of mechanical lifts and slings by three of three certified nursing assistants (CNA) (W, Z, and AA) observed while transferring three of three sampled residents (9, 24, and 25). *Hand hygiene completed by five of five CNAs (W, X, Z, BB, and CC) observed when assisting three of three sampled resident (17, 24, and 50) with cares. *Hand hygiene completed by two of two CNAs (W and Y) observed assisting five of five sampled resident (1, 9, 16, 25, and 40) to eat. *Use of personal protective equipment by two of two CNAs (X and AA) while providing resident care to one of one sampled resident (24) who was on enhanced barrier precautions (EBP). Findings include: 1. Observation on 12/29/25 at 2:24 p.m. in the common area of the Challenging Behavior Unit (CBU) revealed: *There was a sling made of cloth material draped over the sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) in the hallway. *There were no disinfectant wipes available for use on the mechanical lift. *Certified nursing assistants (CNAs) W and Z pushed the sit-to-stand lift in front resident 9's recliner, put the sling that was draped over the lift behind resident 9, and assisted her to a standing position. -While resident 9 was raised to a standing position with the sit-to-stand lift her shirt lifted and the strap of the sling came in direct contact with her skin.	F0880		

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F0880 SS = E	Continued from page 25 *CNAs W and Z did not clean the lift or perform hand hygiene (handwashing) after using the sit-to stand lift to assist resident 9. *CNAs W brought the sling that was used for resident 9 to resident 25's recliner. As she was bringing the sling to resident 25's recliner she dragged the strap of the sling on the floor. *CNAs W and Z placed that sling behind resident 25 and assisted him into his wheelchair while using the sit-to-stand lift. *CNA Z draped the sling back over the sit-to-stand lift and placed the lift in the hallway and did not clean the lift. *Without having performed hand hygiene CNA W assisted resident 9 to a dining table. *Without performing hand hygiene CNA W put on gloves and gave resident 25 Oreo cookies. *CNA W removed her cloves, did not perform hand hygiene, and gave resident 16 a can of pop from the refrigerator and a cookie. *CNA W wiped her nose with the back of her bare hand, did not perform hand hygiene. She then put on a pair of gloves, and assisted resident 9 with eating a donut. *CNA W removed her left glove, rolled the glove into the palm of her hand, and with her right gloved hand continued to assist resident 9 with eating a donut. *While holding the soiled glove in her left hand, CNA W used her left hand to assisted resident 40 to drink pop. *CNA W used her ungloved left hand with the soiled glove in it to lift the lid on the garbage can for a resident, did not perform hand hygiene, and then assisted resident 9 to drink pop. *CNA W then removed the glove from her right hand discarded both gloves and did not perform hand hygiene. *While CNA Y was assisting resident 1 with eating yogurt, she removed her gloves, and did not perform hand hygiene, and continued assisting residents eat their snacks.	F0880		

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F0880 SS = E	Continued from page 26 2. Observation on 12/29/25 at 3:07 p.m. outside resident 25's room revealed: *There was a sign on the outside of his door that indicated he was on enhanced barrier precautions (EBP) which required glove and gown use when providing contact care. *The EBP sign from the Centers for Disease Control and Prevention (CDC), which hung outside of resident 25's door revealed: -It stated, "everyone must: clean their hands, including before entering and when leaving the room." -"Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. -dressing -bathing/showering -Transferring -changing Linens -providing hygiene -changing briefs or assisting with toileting -device care or use.... -wound care: any skin opening requiring a dressing." *There were gowns and gloves hanging on his door and available for use. Review of resident 25's electronic medical record revealed he was on EBP due to a recurring infection to his elbow and a history of Methicillin-resistant Staphylococcus aureus, a bacteria that is resistant to several common antibiotics that spreads from direct contact or contact with contaminated surfaces (MRSA). 3. Observation on 12/29/25 at 4:32 p.m. in The Manor common area of CNA X revealed: *CNA X did not wash his hands and then put on a pair of gloves.	F0880		

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F0880 SS = E	Continued from page 27 *He put foot pedals on resident 17's wheelchair, removed his gloves, did not perform hand hygiene, and then went into resident 24's room to prepare resident 24 to transfer out of his bed. 4. Observation on 12/29/25 at 4:50 p.m. of CNA s X and AA in resident 24's room revealed: *There was a sign on the outside of his door that indicated he was on EBP. *There were gowns and gloves hanging on the outside of resident 24's door. *CNAs X and AA entered resident 24's room, did not apply gowns, used the manual full body lift (a lift and sling used to lift a person's full body), and transfer resident 24 from his bed to his wheelchair. *CNA AA did not clean the full body lift and pushed it into an unoccupied resident room used for storage and left it in that room. 5. Observation and interview on 12/30/25 at 10:58 a.m. with CNAs BB and CC, in resident 50's room revealed: *Resident 50 was sitting in his wheelchair with a urinary catheter (flexible tubing placed in the bladder to drain urine) bag that hung on the side of his wheelchair. *CNAs BB and CC stated they were going to transfer the resident to his bed and then to his recliner. *CNA CC did not wash her hands, and put on a gown and gloves. *CNA BB washed her hands and put on a gown and gloves. *CNAs BB and CC transferred Resident 50 to his bed using a total body lift. *CNAs BB and CC lowered resident 50's pants. CNA CC removed his incontinence brief, wiped his perineal area and buttocks with a wet cleaning wipe, and put barrier cream on resident 50's perineal (genital area) and buttocks. *With those same gloved hands, CNA CC assisted CNA BB to pull up resident 50's pants. *With those same gloved hands, CNA CC then adjusted his urinary catheter	F0880		

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F0880 SS = E	Continued from page 28 (flexible tubing placed in the bladder to drain urine) tubing and bag, transferred him to his recliner, held his hands during the transfer, placed his urinary catheter bag on the side of the recliner, covered him up with a blanket, moved a folding chair, and then took off her gown and gloves, discarded them, and washed her hands. *CNA BB left the residents room while wearing the same gown and gloves on, walked over to the laundry room door, took off her gloves, did not wash her hands, grabbed keys to open the laundry room door, took off her gown, entered the laundry room, exited the laundry room, and then walked over to a sink in the kitchenette and washed her hands. Interview with CNA's BB and CC immediately after the observations above revealed resident 50 was on EBP because he had a catheter and an open skin wound. CNAs were to wash their hands before and after assisting residents with their care and when changing. CNA BB should have taken off her gown and gloves and washed her hands before leaving the resident's room. CNA CC should have removed her gloves, washed her hands, and put on a new pair of gloves after she put the barrier cream on the resident. Review of Resident 50's EMR (electronic medical record) revealed: *He was admitted on 2/9/23. *He had a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) to his right ankle. *He had a urinary catheter. *His 12/25/25 care plan indicated he was on EBP because he had a feeding tube (a flexible tube that delivers liquid food and medicine directly to the stomach when unable to eat or drink by mouth). 6. Interview on 12/31/25 at 10:26 a.m. with CNA T revealed: *Each resident who used the sit-to-stand lift had their own sling. *If a sling became soiled it was to be sent to laundry to be cleaned. *The mechanical lifts were to be cleaned with disinfectant wipes between each resident use.	F0880		

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F0880 SS = E	Continued from page 29 *The disinfectant wipes were stored in a locked closet in the kitchenette. *She said when a resident was on EBP staff were to wear a gown and gloves when they assisted the resident to the toilet, changed their brief, or changed the resident's clothes. *She said gown did not need to be worn when transferring a resident on EBP. 7. Interview on 12/31/25 at 10:43 a.m. with licensed practical nurse (LPN) D revealed: *Hand hygiene was to be performed after using the toilet, after eating, before and after and resident cares, and before and after the use of gloves. *Residents on EBP were identified by the signage and the personal protective equipment on their door. *Residents would be on EBP if they had an infection or a urinary catheter. 8. Interview on 12/31/25 at 3:09 p.m. with director of nursing (DON) B revealed: *She expected hand hygiene to be completed anytime a staff member entered or exited a resident room, before and after providing resident contact care, and after assisting one resident, and before assisting another. *She expected staff to wear a gown and gloves when they provided direct care for residents on EBP, which included transferring residents in their rooms. *Each resident had their individual lift slings. *She expected the lifts to be cleaned between each use. *She verified not cleaning the lifts between resident and sharing lift slings could risk infections and allow for cross contamination between residents. *She stated when the sling strap was dragged on the floor, it was soiled and should have been sent to laundry, not used on another resident. 9. Review of the provider's 11/2025 LTC (long term care)- Hand Hygiene policy revealed:	F0880		

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F0880 SS = E	Continued from page 30 *"Hand hygiene (HH) continues to be the primary means of preventing the transmission of infection." *"HH, either with soap and water or with alcohol based hand rub (ABHR): 1. immediately before touching a resident 2. before a clean procedure or handling an invasive medical device 3. after contact with potential for body fluid or contaminated surfaces 4. after touching a resident or the resident's immediate environment 5. after removing gloves" 10. Review of the provider's undated LTC - Transmission Based Precautions and Enhanced Barrier Precautions policy revealed: *Purpose: -To provide infection prevention and control recommendations for long-term-care. -Transmission of infectious organisms within a healthcare setting requires three elements to be linked: -A source (or reservoir) of infectious organisms -A susceptible host -A means of transmission for the organism. -Interruptions of this link in the chain of infection is achieved primarily by separating an individual physically (Transmission Based Precautions) or using a barrier (Enhanced Barrier Precautions)." *"[Provider] will incorporate the use of Standard Precautions, Enhanced Barrier Precautions, and additional Transmission Based Precautions as indicated for known, suspected or incubating infections or communicable diseases, and for the protection of residents, visitors, and staff from potential exposure to communicable and transmissible diseases." *"Enhanced Barrier Precautions are used during high contact resident care activities for the following	F0880		

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F0880 SS = E	Continued from page 31 residents: Infection or colonization with an MDRO when contract precautions do not otherwise apply Wound requiring a dressing, regardless of MDRO status (e.g. central line, urinary catheter, feeding tube, trach) If a, b, or c: gown and gloves to be worn during high contact resident care activities, including (but not limited to) i. dressing ii. Bathing or showering iii. Transferring iv. Providing hygiene v. changing linen vi. Device care or use (Central lines, urinary catheter, feeding tube, trach adjustment/care) viii. Wound care (any wound requiring a dressing) *"Staff is responsible for complying with precautions and for tactfully calling observed infractions to the attention of offenders." *"In addition to what is posted on precautions signage, follow Standard Precautions by type of exposure anticipated and with additional tasks: a. Work from 'clean to dirty' b. Limit opportunities for 'touch contamination'-protect yourself, others, and the environment. If contamination occurs, remove PPE [personal protective equipment], complete hand hygiene and don clean PPE c. Do not touch your face or adjust PPE with contaminated gloves d. Do not touch environmental surfaces (including privacy curtains) except as necessary during resident care" *"Remove PPE appropriately and complete hand hygiene before leaving the room"	F0880		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 12/30/25. Sunset Manor Avera Health was found in compliance.	E0000		

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 reverse for further 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
Robin R. Stockland	Administrator	1/22/26

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		A. BUILDING 01 - MAIN BUILDING 0... B. WING	12/30/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 12/30/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sunset Manor Avera Health (Building 01) was found not in compliance. Please mark an F in the completion date column for the K241 deficiency identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K222, K321, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0222 SS = E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the	K0222	K0222 Corrective Action: Sunset Manor License was changed to 58 beds of Memory Care in order to reflect the need for the entire facility to be locked in order to protect the residents and keep them safe due to their medical and mental conditions. The updated License is effective as of 12/31/2025 and will be renewed annually to include the 58 beds of Memory Care. Specialty Security Door Locking System Policy was developed for the entire facility as of 12/30/25 to include language pertaining to 2012 Life Safety Code (NFPA 101 or LSC) and South Dakota Administrative Rule 44:73:04:14 Memory Care Units. Admission Packet was updated with a section for family/ resident education. All residents and their family members/ guardians will be notified of the locked/controlled exit doors upon admission and this will be included in the admission packet. In the admission packet the wording will be as follows: "Our facility is considered a memory care facility and uses controlled exits to ensure resident safety from wandering, with instant staff access to all areas for resident well-being." All staff, residents and families will be educated by 2/4/26 that the entire facility is now designated as Memory Care and that our license has been updated.	2/4/26

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 reverse for further 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
Robin R. Stockland	Administrator	01/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Avera Health	129 E CLAY ST , IRENE, South Dakota, 57037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0222 SS = E	Continued from page 1 device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation, testing, interview, and email communication the provider failed to provide operable egress doors as required at three randomly observed exit door locations (manor wing north and south exits, and dining room exit). Findings include: 1. Observation and testing beginning on 12/30/25 at 12:42 p.m. revealed the egress doors for the north and south ends of the manor wing, as well as the exit door near the dining room were locked with electromagnets. Those doors would not open when pushed on in the	K0222		

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K0222 SS = E	Continued from page 2 direction of egress. Additionally, those doors would not enter a delayed-egress state when tested. Further testing that same day during the observed fire drill, revealed the electromagnetic locks on those exit doors released, and those doors would open upon activation of the building's automatic fire alarm system. Continued testing at that same time revealed those same conditions also existed for the exit door near the dining room. Interview with the maintenance director at the time of the observations confirmed those conditions. Further interview with the administrator during the exit interview that same day revealed electronic keys were carried by all staff at all times, and those keys could open those doors. When asked if all the residents in the affected areas had doctors' orders allowing them to be in a locked unit for their own security, the administrator stated at the current moment they did not. Email communications from the administrator that same day, after the survey concluded, were reviewed and confirmed that finding.	K0222		
K0241 SS = C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This STANDARD is NOT MET as evidenced by: Based on observation and record review, the provider failed to maintain two conforming exits on each smoke compartment of the building. One of two areas (east basement mechanical room) had only one conforming exit. Findings include: 1. Observation on 12/30/25 at 1:48 p.m. revealed the exit stairway from the basement mechanical room discharged into the corridor system on the main level. The second exit from the basement mechanical room was through a window to an area well equipped with a fixed ladder. Review of the previous survey data dated 8/6/24	K0241		F

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K0241 SS = C	Continued from page 3 indicated that condition had existed since the original construction. The deficiency would not affect any residents. The building meets the FSES. Please mark an F in the completion date column to indicate correction of the deficiency identified in K000.	K0241		
K0321 SS = D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe	K0321	KO321 Corrective Action: Maintenance Director fixed soiled linen door the same day, 12/30/25, with no issues noted since that time. Monitoring: Audits will be completed by Maintenance Director or designee to ensure doors latch properly on a weekly basis x 4 weeks and then monthly x 5 months. All results will be reported at the monthly QAPI meeting by Maintenance Director or designee. Door checks will then remain on the Maintenance Director's monthly checks during safety walkthroughs to ensure continued compliance.	12/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0321 SS = D	Continued from page 4 Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain one randomly observed hazardous area (soiled linen room) as required. Findings include: 1. Observation on 12/30/25 at 11:35 p.m. revealed the soiled linen room was a one-hour fire-rated enclosure. That room had a three-hour fire-rated corridor door with an automatic door closer. Testing of that door at that same time revealed it would not close and latch with the operation of the closer. Further testing at that same time revealed that corridor door would not latch into the frame even when it was pulled shut. The doors strike would not engage in the strike plate on the door's frame. Doors in fire-rated enclosures are required to close and latch under the operation of an automatic door closer. Interview with the maintenance director at the same time of the observations and testing confirmed those findings. The deficiency affected two of numerous requirements for hazardous storage rooms.	K0321		
K0712 SS = D Bldg. 01	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by:	K0712	K0712 Corrective Action: Re-education is being provided to all current staff by no later than 2/4/26. Education will be completed at an all staff meeting on 1/28/26 or during the CNA and nurses' meetings on the same date. Any staff not in attendance will be provided this education on their next shift, no later than 2/4/26. All new staff will continue to be educated on Fire Safety, Fire Drills and R.A.C.E during new hire orientation. All staff are educated on an annual basis. Monitoring: Fire Drills will be conducted weekly x 4 weeks by the Maintenance Director or designee, then 2x/month x 1 month and monthly x 3 months with all results reported at the monthly QAPI meeting by the Maintenance Director or designee for those 6 months. The Fire Drills will continue on a monthly basis per regulation to ensure continued compliance.	2/4/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Avera Health	129 E CLAY ST , IRENE, South Dakota, 57037

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K0712 SS = D Bldg. 01	Continued from page 5 Based on observation and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedure (Closing corridor doors). Findings include: 1. Observation beginning on 12/30/25 at 1:57 p.m. revealed a drill for a simulated fire in room 29 was being conducted. Further observation at that same time revealed the medical records staff person was the initial person responding to that location. That medical records staff person did not follow each of the facility's R.A.C.E. (Rescue, Alarm, Confine/Contain, and Evacuate) steps when responding. She failed to close the door to the affected room as part of the initial response (Confine/Contain). Continued observation through the entirety of the fire drill revealed that the door to that room (29) was not closed to confine the effects of the simulated fire. Interview with the maintenance director immediately after the fire drill confirmed those findings. He stated the medical records staff person was familiar with the provider's fire drill procedures, but must have forgotten that step. He agreed the door to room 29 should have been closed.	K0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING 02 - BUILDING 02 B. WING	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Avera Health	129 E CLAY ST , IRENE, South Dakota, 57037

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K0000	INITIAL COMMENTS A recertification survey was conducted on 12/30/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sunset Manor Avera Health (Building 02) was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K781 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0781 SS = D Bldg. 02	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the provider failed to ensure portable space heaters used in staff areas had heating elements that did not exceed 212 degrees Fahrenheit (100 degrees Celsius) as required. Findings include: Observation beginning on 12/30/25 at 11:47 a.m. revealed a "Mainstays" brand ceramic element portable space heater was in use in the Minimum Data Set coordinator3s office (marked "Clean Linen"). That space heater was not used in a prohibited area; however, for portable space heaters to be used in nonsleeping staff and employee areas, they are required to have heating elements that do not exceed 212 degrees Fahrenheit (100 degrees Celsius).	K0781	K0781 Corrective Action: Portable space heater was removed on 12/30/26 and all staff with offices were educated that day. System change: No space heaters will be allowed in the facility unless they are rated and documentation is provided that they have heating elements that do not exceed 212 degrees Fahrenheit (100 degrees Celsius). If an approved space heater is purchased for staff areas, the Maintenance Director will be notified immediately so that he can begin monthly checks during the monthly safety walkthroughs. Monitoring: Maintenance Director or designee will audit monthly x 6 months that space heaters that are not allowed are being used in the facility. All results will be reported at the monthly QAPI meeting by the Maintenance Director or designee.	12/30/25

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 reverse for further 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
Robin R. Stockland	Administrator	01/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Avera Health	129 E CLAY ST , IRENE, South Dakota, 57037

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K0781 SS = D Bldg. 02	Continued from page 1 Interview with the director of maintenance at the same time as the observation revealed he was unaware that space heater was in use in that location. Further interview at that same time revealed the provider did not have documentation indicating that portable space heater's heating elements did not exceed 212 degrees Fahrenheit (100 degrees Celsius).	K0781		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10636	A. BUILDING: _____ B. WING _____	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET MANOR AVERA HEALTH	129 E CLAY ST IRENE, SD 57037

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/29/25 through 12/31/25. Sunset Manor Avera Health was found not in compliance with the following requirements: S206, S210, S253, and S294.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel	S 206	S206 Correction to the individual: RN U will be required to complete all missing education prior to picking up any additional shifts at Sunset Manor. CNA W will be required to complete all missing education by 1/31/26. System Changes: Agency staff will be required to complete our full Mandatory Extravaganza to include all required education pieces. This will be done upon hire and annually. Full compliance packets will be requested of all agency staff that are sent to Sunset Manor including all required training and education. Information has been sent to all agencies as of 1/22/26 which includes all needed training and education. Monitoring: Audits will be done by HR, DON/ADON or designee weekly x 4 weeks, every other week x 2 month & monthly x 3 months to ensure that all education and training is received. All results will be reported at monthly QAPI meetings by HR, DON/ ADON or designee.	1/31/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland — TITLE: Administrator — (X6) DATE: 1/30/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10636	A. BUILDING: _____ B. WING _____	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 1 education based on the facility's identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on personnel record review, employee training record review, interview, and policy review, the provider failed to ensure that two of five newly hired employees (U and W) reviewed completed the required orientation training within 30 days of their hire date. Findings include: 1. Review of employee personnel records revealed: *Employee U was hired on 11/5/25 as a contracted travel registered nurse (RN). *Employee W was hired on 1/2/25 as a contracted travel certified nursing assistant (CNA). 2. RN U's employee training records revealed she had not completed the required training within 30 days of her hire date regarding the topics of: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *Dining assistance, nutritional risks, and hydration needs of residents. 3. Review of CNA W's employee training records revealed she had not completed the required training within 30 days of her hire date regarding the topics of: *Fire prevention and response. *Emergency procedures and preparedness. *Proper use of restraints. *Confidentiality of resident information. *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. *Care of residents with unique needs.	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 2 *Abuse and neglect, misappropriation, and mistreatment. 4. Interview on 12/31/25 at 11:30 a.m. with human resources (HR) I revealed: *The provider used an online training program for employee-required training. *HR I verified employees U and W had not completed all the required training within 30 days of their hire date. *She was responsible for ensuring all employees had the required training completed within 30 days of hire. *She had not verified employees U and W had completed all the required trainings because they were contracted travel staff. *She stated CNA W had been contracted with the provider while employed by a different travel staffing agency prior to her current contract, but HR I was unable to locate CNA W's training records. 5. Interview on 12/31/25 at 1:42 p.m. with administrator A revealed: *The provider used an online training program for new employee-required training. *HR I was responsible for being sure the required training had been completed within 30 days of hire. *She expected all required training to be completed within 30 days of being hired and annually by all staff members. *She expected the contracted travel agency to provide a packet of the education that was completed by the contracted staff member prior to that staff members' hire date. *Administrator A stated she did not feel they were responsible for ensuring the contracted travel staff had completed the required training.	S 206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10636	A. BUILDING: _____ B. WING _____	12/31/2025

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S 206	Continued From page 3 6. Review of the provider's 3/4/25 Staff Education - Upon Hire and Annually policy revealed: *"To ensure compliance with regulation 44:04:04:05 regarding personnel training by providing formal orientation and ongoing education for all staff members." *"New Hire Education Requirement: All new hires must complete our orientation packet along with our Mandatory Extravaganza training prior to beginning on-the-job orientation. This initial education ensures staff understand essential topics before engaging in resident care or facility operations. Training includes: All Staff: Mandatory Extravaganza -Resident Rights -HIPPA (Health Insurance Portability and Accountability Act) and Confidentiality -Life Safety (fire, electrical, oxygen safety, hazard communication) -Emergency Preparedness	S 206		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable	S 210	S210 Correction to the individual: LPN D and CNA S's health evaluations were reviewed and signed off by DON B on 1/22/26. RN U's health evaluation was received by the facility on 12/30/25 and was signed off by DON B on 1/22/26. CNA W's health evaluation was received by the facility on 8/8/25 for her contract start date of 8/12/25 and was signed off by DON B on 1/22/26. System Changes: Health evaluations will be completed by all staff, including agency staff members upon hire and will be reviewed by licensed medical professional, signed and dated. All staff, including agency staff, will complete TB testing or blood draw within 14 days of hire. They will also complete TB education upon hire and annually. (Continued on next page)	2/4/26

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S 210	Continued From page 4 disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee record review, interview, and policy review, the provider failed to ensure a health evaluation (an employee evaluation reviewed by a licensed healthcare professional to ensure no personnel is infected with any reportable communicable disease that poses a threat to others) was completed within fourteen days of hire for four of five employees (D, S, U, and W) reviewed. Findings include: 1.Review of licensed practical nurse (LPN) D's employee file revealed: *She was hired on 10/31/25. *Her health evaluation was not signed to indicate the health evaluation had been reviewed by a licensed healthcare professional. 2. Review of certified nursing assistant (CNA) S's employee file revealed: *She was hired on 11/5/25. *There was no date on CNA S's health evaluation to document when it had been completed. *Her health evaluation was not signed to indicate the health evaluation had been reviewed by a licensed healthcare professional. 3. Review of registered nurse (RN) U's employee file revealed:	S 210	(S 210 Continued from page 4) TB education will be done with all staff by 2/4/26 at all staff meeting on 1/28/26 or during the CNA and nurses meetings on the same date. Any staff not in attendance will be provided this education on their next shift, no later than 2/4/26. TB education is also being updated to add a quiz since the education was already being completed with our current mandatory extravaganza with Avera Education and Staffing. Monitoring: Audits will be done by HR, DON/ADON or designee weekly x 4 weeks, every other week x 2 months, then monthly x 3 months to ensure all health evaluations and TB testing has been completed and signed appropriately. All results will be reported at the monthly QAPI meetings by HR, DON/ADON or designee.	

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S 210	Continued From page 5 *She was hired on 11/5/25. *She did not have a completed health evaluation in her employee file. 4. Review of CNA W's employee file revealed: *She was hired on 1/2/25. *She did not have a completed health evaluation in her employee file. 5. Interview on 12/31/25 at 11:00 a.m. with human resources (HR) I revealed: *She was responsible for making sure the employee health evaluations were completed upon hire. *She verified LPN D and CNA S's health evaluation was not signed by a licensed health professional to indicate it had been reviewed. *She verified CNA W and RN U did not have a health evaluation in their employee files. 6. Interview on 12/31/25 at 1:42 p.m. with administrator A regarding employee health evaluations revealed: *HR I was responsible for being sure the health evaluations were completed upon hire and all health evaluation were each staff's employee file. *She verified the health evaluations were to be dated and signed by a licensed health professional to indicate they had been reviewed and when. *She expected the health evaluations to have been completed by the contracted travel staffing agency for the contracted travel staff and given to the provider prior to those staff members beginning work at the facility. 7. Review of the provider's 3/4/25 Post-Offer Assessment and Additional Required Physical Exams policy revealed: *"Job applicants who are offered employment	S 210		

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S 210	Continued From page 6 with [the provider] must complete a post-offer assessment. The employment offer is contingent upon satisfactorily completing a Medical History and Past Occupational History Survey and a post-offer assessment." *"A post-offer assessment is required for all individuals offered employment with [the provider] to: -Determine that the prospective employee is physically capable of performing the essential job functions of the position, with or without reasonable accommodation ... -Determine that the prospective employee is free from communicable diseases as required by state regulations." *"South Dakota Administrative Rule 44:75:04:06. All personnel shall be evaluated by a licensed health professional for freedom of a reportable communicable disease that poses a threat to others."	S 210		
S 253	44:73:04:14 Memory Care Units Each facility with a memory care unit shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement must be documented in the resident's chart and must be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming must be provided to residents of the facility and must be documented by the facility in the overall plan of care pursuant to § 44:73:06;05; (3) Confinement may not be used as a punishment or for the convenience of the personnel;	S 253	S 253 Addendum - Corrected to Individual: Physician orders were obtained for all residents in the Manor on 12/30/25 that state, "I require specialized security locked doors for my safety to prevent elopement due to my clinical and psychiatric needs." RS 1/30/26 Corrective Action: Sunset Manor License was changed to 58 beds of Memory Care in order to reflect the need for the entire facility to be locked in order to protect the residents and keep them safe due to their medical and mental conditions. The updated License is effective as of 12/31/2025 and will be renewed annually to include the 58 beds of Memory Care. Specialty Security Door Locking System Policy was developed for the entire facility as of 12/30/25 to include language pertaining to 2012 Life Safety Code (NFPA 101 or LSC) and South Dakota Administrative Rule 44:73:04:14 Memory Care Units. (Continued on next page)	2/4/26

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S 253	Continued From page 7 (4) Confinement and its necessity must be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement must be communicated to the resident's family; (5) Locked doors must conform to Sections: 18.2.2.2.5 and 19.2.2.2.5 of the NFPA 101 Life Safety Code, 2012 edition; and (6) Any personnel assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. at least one caregiver must be on duty in the memory care unit at all times. For the purposes of this section, the term "therapeutic programming" means any purposeful activity that fosters social, emotional, physical, cognitive, and mental wellbeing. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to accurately complete and report the number of licensed beds for two out of two locked units on their South Dakota Department of Health Nursing Facility License. Findings include: 1. Review of the provider's South Dakota Department of Health Nursing Facility License revealed: *It's effective date was 7/1/2025 *It's expiration date was 6/30/2026 *It indicated they had a memory care unit with eight beds. 2. Interview on 12/31/25 at 8:35 a.m. with director of nursing (DON) B and administrator A revealed: *The traumatic brain injury (TBI) unit was opened	S 253	S 253 (Continued from page 7) Admission Packet was updated with a section for family/resident education. All residents and their family members/guardians will be notified of the locked/controlled exit doors upon admission and this will be included in the admission packet. In the admission packet the wording will be as follows: "Our facility is considered a memory care facility and uses controlled exits to ensure resident safety from wandering, with instant staff access to all areas for resident well-being." All staff, residents and families will be educated by 2/4/26 that the entire facility is now designated as Memory Care and that our license has been updated.	

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S 253	Continued From page 8 in 2008 with eight resident beds. *The challenging behaviors unit (CBU) was opened in 2014 with eleven resident beds. *Administrator A stated they had always filled out the nursing facility license application the same way and never thought about adding the CBU beds or any other beds in resident-living areas with locked doors on the license application. *In January 2025, the facility changed from using a key coded door locking system on the facility's doors to using a badge swiping system to unlock those doors. The badge cards were carried by staff members to allow them to enter and exit all the doors throughout the facility. Prior to January 2025 the doors to the resident-living areas located outside of the CBU and TBI units were able to be unlocked with the key code or by pushing on the door's lock bar for a period of time that would then unlock the door in case of an emergency. Residents and visitors did not have badges that would allow them to enter and exit all of the facility's doors at will or in case of an emergency, other than automated lock release triggered by their fire alarm system. 3. Review of the providers' revised 12/30/25 Specialty Security Door Locking System Policy revealed: *"Due to the high number of residents with either dementia and/or a psychiatric disorder, [facility name] needs to provide a locked environment to prevent elopements and subsequent injuries." *"[Facility name]'s Medical Director agrees that due to the clinical and psychiatric needs of our residents, all doors in the facility need to be locked to prevent further elopements and subsequent injuries or even death. All staff are provided with a key card and are educated on how to use the card to open all doors." *"All residents in the [facility name] will have a	S 253		

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S 253	Continued From page 9 physician order."	S 253		
S 294	44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, must be written, prepared, and served as ordered by each resident's physician, physician assistant, nurse practitioner, or authorized dietitian. Each menu must be written at least one week in advance. A dietitian shall annually approve, sign, and date each planned menu for the facility. The dietitian shall review any menu changes from month to month. Each menu as served must meet the nutritional needs of the resident in accordance with the orders of a physician, physician assistant, nurse practitioner, or dietitian and the Dietary Guidelines for Americans, 2020-2025. The facility shall file and retain a record of each menu as served for thirty days. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the menus were signed and approved by a dietician as required. Findings include: 1. Record review on 12/30/25 at 1:00 p.m. of the provider's weekly menus revealed: *The menus were on a three-week rotation. *The menus were labeled as "Regular/NAS [no added salt]" and the second menu was identified by the therapeutic diet level. *There were no fruit servings identified on the	S 294	S 294 Corrective Action: RD EE signed updated menus on 1/5/26. System changes: During monthly RD EE's consultations, DM R will review menus with RD EE and assure that the menus currently in use have been signed prior to implementation. Monitoring: DM R will audit extension menus & weekly menus to ensure they have been reviewed and signed by RD EE monthly x 6 months. All findings will be reported at monthly QAPI meetings by DM R or designee.	1/5/26

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S 294	Continued From page 10 regular/NAS meals on any day for all three weeks. *The therapeutic diets had a fruit serving twice a day on the menus. *There were no signature or date on the regular/NAS menus or the therapeutic diet menus. *The weekly menu extensions (therapeutic diets) and the emergency menus were last signed by registered dietician (RD) EE on 2/13/25 and in the previous years were signed at least twice yearly. 2. Interview on 12/30/25 at 2:44 p.m. with dietary manager (DM) R revealed: *The regular/NAS menus had not been signed by the registered dietician. *She had not had the registered dietician sign those menus to indicate that she had reviewed and approved those menus in the eight years she had been the dietary manager. 3. Interview on 12/31/25 at 11:34 a.m. with RD EE revealed: *The provider had spring/summer menus and fall/winter menus. *She was responsible for reviewing the spring/summer and fall/winter menus before the menus switched from one to the other. *She had not been given the fall/winter menus to review for nutritional adequacy and compliance. *She verified the fall/winter menus were the current menus being served to the residents. *She verified the regular/NAS menu did not identify daily servings of fruit. *Her signature for the menu extensions and the emergency menus on 2/13/25 were for the spring/summer menus. 4. Interview on 12/31/25 at 2:40 p.m. with DM R revealed:	S 294		

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S 294	Continued From page 11 *DM R was responsible for creating the weekly menus. *After she created the menus, the regular/NAS and therapeutic menus were to be reviewed by the dietician for nutritional adequacy. *RD EE would adjust the menus if the menus were not nutritionally adequate for the residents and then would sign the menus to indicate that she reviewed and accepted the menus. *DM R verified the fall/winter menus had not been reviewed and approved by RD EE for nutritional adequacy. *She stated she must have forgotten to send them to RD EE for review and approval prior to changing to the fall/winter menu. 5. Review of the undated Consultant Registered Dietician (Long-Term Care) job description revealed: *"Review and approve menus for nutritional adequacy and compliance". *"Ensure documentation meets CMS [Centers for Medicare and Medicaid Services] and state regulatory requirements". 6. Review of the provider's 2023 Menu Planning policy revealed: *"Regular and therapeutic menus will be written to provide a variety of foods served on different days of the week, adjusted for seasonal changes, and in adequate amounts at each meal to satisfy recommended daily allowances. If menus are written in cycles, they are rotated." *"Regular and therapeutic menus will be written by the facility's food and nutrition professional in accordance with the facility's approved diet manual or purchased from an approved vendor. The registered dietician nutritionist (RDN) or designee will approve all menus." Review of the provider's 2023 Menu Checklist:	S 294		

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S 294	Continued From page 12 Nutritional and Regulatory Requirements policy revealed a resident was to be served "Fruit: 2 to 2 ½ cup equivalents per day".	S 294		