STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	436100	A. BUILDING _____ B. WING _____	C 08/08/2024

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) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/5/24 through 8/8/24. Sunset Manor Avera Health was found in compliance. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/5/24 through 8/8/24. Areas surveyed included staff-to-resident abuse with use of physical restraint, resident-to-resident abuse, and elopement. Sunset Manor Avera Health was found not in compliance with the following requirements: F604 and F641.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 604	F 604 Correct to individual: as soon as this issue was discovered, the facility completed a State Report,an investigation was done. Resident #37 was assessed and no injuries or bruises were noted. Resident #37 did not remember the incident. CNA H's agency was notified immediately and told that CNA H was no longer allowed in our facility. The agency did terminate CNA H's employment. System correction: a new process for all new employees, including new agency staff has been implemented. This includes the following; new staff orientation check list with training videos now have area to initial and date when each video was completed. There is also an area to sign (affidavit) that states, "I, (staff name), as a healthcare professional, understand that I am a mandatory reporter while in the building. I also understand that as a healthcare professional, I will not abuse residents." (F 604 Continued on next page)	09/22/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Robin E. Stockland

TITLE
Administrator

(X6) DATE
08/28/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	Continued From page 1 §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on a facility-reported incident (FRI) review, observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (37) who was cognitively impaired received adequate care and monitoring to ensure she was free of physical restraints imposed for discipline or convenience and not required to treat the resident's medical symptoms that resulted in an incident of resident abuse by one of one agency staff member (H). Findings include: 1. Review of the South Dakota Department of Health (SD DOH) event report for resident 37 on 6/28/24 revealed: *She returned from the hospital on 6/28/24 at 6:35 p.m., was restless, and had tried multiple times to stand up from her chair. -She was unsteady when walking. -She was redirected to sit in her wheelchair by agency certified nursing assistant (CNA) H. -"For nearly an hour and half resident [resident 37] continues to try to stand up or get out of the wheelchair and resists against [first name of agency CNA H] but is physically restrained against and to the wheelchair by [first name of	F 604	(F 604 continue from previous page) System correction continued: For new agency staff, they will be required to complete orientation videos and read specific facility policies prior to picking up shifts at our facility. The videos that will now be required are; Trauma Informed care, Positive Dementia care - Our calling, Our commitment, Our culture, De-escalating agressive behavior of a person with dementia, Resident Rights, Abuse, Neglect & Exploitation-Recognition & Reporting, along with Restraint Devices: Promoting a Restraint Free Culture. The policies that must be read include; resident rights, abuse policy, behaviors and interactions plan, cell phone policy and the weather and fire safety plans. These all must be completed, signed off and sent to DON prior to any new agency staff being allowed to work in our facility. All current nursing staff, including agency staff will need to complete the above training with signed affidavit by 09/22/2024 or they will no longer be able to pick up shifts here until it is completed. Monitoring of system: audits will be completed for all orientation training checklists and for signed affidavits. Audits will be completed by DON, Admin or designee weekly x 4 weeks, 2x/monthly for 3 months, followed 1x/monthly for 3 months. All audit results will be reported and reviewed monthly at QAPI meetings by DON, Admin or designee.	

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F 604	Continued From page 2 agency CNA H]." --"During this time [first name of agency CNA H] is physically holding [resident 37's first name]'s arms down to the wheelchair, what appears to be digging her chin into [resident 37's first name]'s scalp, towers over resident and appears to have several verbal exchanges with resident." -"At 8:51 p.m. nurse [agency registered nurse (RN) I] comes back to unit and rubs [resident 37's first name]'s back and talks with her which calms her down." -"2nd nurse [LPN J] comes back to unit at 8:54 p.m. and also talked to [resident 37's first name] and they [agency RN I and LPN J] take her to recliner on unit and she does not want to sit there ..." -"They [agency RN I and LPN J] then take her down to her room and she is calm." 2. Observation on 8/6/24 at 2:07 p.m. of resident 37 revealed she was in the activity room involved with a resident group activity led by a local pastor. She was sitting in a chair and actively singing a hymn with the pastor and other residents. 3. Interview on 8/6/24 at 4:00 p.m. with resident 37 in her room revealed: *She enjoyed pastor visits, watching movies, and loved to read. *She could not remember any staff member being upset with her, raising their voice to her, or holding her down, stating "They [the staff] are very good to me." *She had no recollection of the 6/28/24 incident or having been to the hospital that day. 4. Review of Resident 37's electronic medical record (EMR) revealed: *She was admitted to the facility on 6/26/23.	F 604		

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F 604	Continued From page 3 *After her admission, she was moved to a room in the provider's challenging behavior unit (CBU). *She was sent to the [another community] hospital's emergency room on the afternoon of 6/28/24 after the resident was exhibiting slurred speech, left-sided weakness, and facial droop. -She had been given IV [intravenous] fluids and IV Ativan [medication given to relieve anxiety] for her CT [computed tomography] scan while at the hospital. -She returned from the hospital on 6/28/24 at 6:30 p.m. to her room in the CBU. *Her diagnoses included: -Unspecified dementia, with other behavioral disturbances. -Bipolar disorder. -Alzheimer's disease. -Paroxysmal atrial fibrillation. *Her 6/17/24 annual minimum data set (MDS) assessment revealed: -Her brief interview for mental status (BIMS) was scored at 12, which indicated she was moderately impaired cognitively. -She had exhibited no behavioral symptoms in the past week. -She was independent with dressing, eating, and walking with a walker. -She was independent with toileting but had some occasional urinary incontinence. Review of Resident 37's EMR progress notes revealed: *On 6/28/24 a progress note was entered by director of nursing (DON) B at 2:56 p.m. which stated, "CNA came to recorder [DON B]'s office around 1415 [2:15 p.m.] and reported that resident has had a significant decline this afternoon ... was very lethargic, required 2 [staff members] extensive assist to get to bed. Staff	F 604		

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F 604	Continued From page 4 assisted her to bed ... she was leaning to the right, weak with garbled speech ... This recorder [DON B] notified Dr [last name of physician] and went immediately to room to examine resident. Performed stroke screen, able to shrug shoulders, stick out tongue, squeeze fingers with grip weakness on the left, was not able to sit up unsupported with leaning to both sides, more-so to the left noted. Resident had very garbled speech ... Dr [last name of physician] ... requests her to be sent out via EMS [emergency medical services]. [First name of guardian] notified of condition and that resident will be sent out via ambulance." *On 6/28/24 a progress note was entered at 3:06 p.m. by LPN K updating the resident's guardian on her status. *On 6/28/24 a progress note was entered at 9:35 p.m. by RN I which stated "Patient returned from ED [emergency department] at 1830 [6:30 p.m.]. Report received from discharging nurse. CT [computed tomography] scans negative. CBC [complete blood count], CMP [comprehensive metabolic panel], UA [urinalysis] all WNL [within normal limits]. Given IV [intravenous] fluids and IV [intravenous] Ativan [medication given to relieve anxiety]. No discharge diagnosis ... Patient is agitated and looking for her nephew to pick her up. Combative with staff. Took HS medications with no problems, went to bed at 2130 [9:30 p.m.] ..." *There was no progress note related to the physical restraint of the resident by agency CNA H 5. Review on 8/6/24 of resident 37's current care plan revealed: *A focus area "I have memory problems, have poor safety awareness, and make poor decisions.	F 604		

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F 604	Continued From page 5 I have clear speech. I can usually express my needs. I can usually understand others." *A focus area "I take psychotropic medications. I have physical outbursts. I have mood problems ..." -Interventions included: --"I admitted to [name of provider's nursing unit] on 06-26-2023 from [the provider's trade name] behavioral health center in [another community], SD. I need 24 hour supervision ... I was approved for challenging behavior [unit] ... on 6/26/2023 ..." --"I am followed by [provider's trade name] behavioral health for medication management." 6. Interview on 8/7/24 at 3:07 p.m. with DON B regarding the 6/28/24 incident revealed: *Agency CNA H had been scheduled to work at 3:00 p.m. on 7/3/24 but did not show up for her shift. *She reached out to CNA H by cell phone with no response. *Another unidentified agency CNA had informed her that agency CNA H had left her assignment at the nursing home for her home state of Louisiana due to her being left in the behavior unit by herself. *On 7/3/24 she emailed the agency that employed CNA H and asked regarding CNA H. *The reply she received informed her that CNA H was leaving her contract with the provider due to being alone in the behavioral unit for a couple of hours last Friday night, 6/28/24. *She was unaware of the 6/28/24 incident until Wednesday, 7/3/24. *On 7/3/24, after the emailed reply, she and administrator A reviewed the video footage from the CBU unit from Friday, 6/28/24. -Agency CNA H was seen physically in front of resident 37, who was seated in a wheelchair,	F 604		

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F 604	Continued From page 6 holding the resident's forearms down on the wheelchair's armrests and agency CNA H's chin resting on the resident's forehead. *After reviewing the video footage, DON B asked the CBU unit coordinator about the 6/28/24 incident and agency CNA H. -CBU unit coordinator stated CNA H had worked Friday evening, 6/28/24 and then the following Sunday, Monday, and Tuesday. -Two CNAs that were scheduled on the CBU at 7:00 p.m. on 6/28/24. -The CBU unit coordinator had stated that no one had reported anything to her regarding the incident on 6/28/24. *DON B stated the CBU unit coordinator had resigned from her position with the provider two weeks ago and no longer worked at the facility. 7. Interview on 8/7/24 at 3:48 p.m. with administrator A and DON B regarding the 6/28/24 incident revealed: *Both agreed that the abuse of resident 37 had occurred with agency CNA H physically restraining the resident for a combined time of 20 minutes that occurred periodically throughout the ninety minutes she was attending to the resident on the CBU unit. -Other staff were seen coming in and out of the CBU unit during this time, but none of the staff had witnessed CNA H physically restraining the resident. --Agency RN I had passed medications on the CBU unit and another nursing unit. --CNA M and LPN J were also seen on the CBU unit that evening. --Agency CNA L had been scheduled to be on the CBU unit that evening, but was not seen on the video footage during that time as she may have been pulled to another nursing unit.	F 604		

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F 604	Continued From page 7 *DON B stated resident 37's assessment after the incident revealed no harm was evident, but based on the video footage, she verified the physical restraint of the resident had occurred. *Both agreed the video footage was limited to the hallway by the nursing station. 8. Review of the provider's January 2024 LTC (long term care) Abuse Prohibition policy revealed: *"It is essential for facilities to prohibit and prevent abuse, neglect, exploitation of residents ... including freedom from physical ... restraints not required to treat a resident's medical symptoms. The facility will have systems in place to encourage and support all residents, staff, ... in reporting any suspected acts of abuse ..." *Physical restraint "is defined as any manual method, ...that meets all of the following criteria:" -"i. Is attached or adjacent to the resident's body;" -"ii. Cannot be removed easily by the resident; and" -"iii. Restricts the resident's freedom of movement ..."	F 604		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SDDOH) complaint report review, record review, policy review and interview the provider failed to ensure 15 of 22 (2, 3, 7, 8, 14, 16, 20, 23, 25, 26, 29, 33, 35, 41, 43) Elopement risk evaluations were completed accurately to ensure resident	F 641	F641 Correct to individuals: all residents at our facility will have a new elopement risk evaluation completed by 9/6/2024 and if residents are at risk for elopement their care plans will be updated. System correction: Sunset Manor went live with a new electronic medical record as of 7/1/2024 which is PointClickCare (PCC). In PCC, the elopement assessments are calculated and scored by PCC. This will eliminate the inaccuracy of the scoring or misinterpretation by the nurses of the scoring protocol, which was the issue in our old system American Healthtech (AHT). (F641 is continued on the next page)	09/06/2024

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F 641	Continued From page 8 safety. Findings include: 1. Review of SDDOH complaint report revealed: *Resident 43 had eloped from the building on 7/17/24 out a door that had an alarm. *The alarm did not sound and alert staff to a resident exiting the building. *Staff observed resident 43 walking with a walker across the front lawn of the building. *They assisted him back into the building. *Nurse completed vitals and assessed him to make sure he was okay. *Staff checked all other doors in the building, making sure all other alarms were working. 2. Review of resident 43's electronic medical record (EMR) revealed: *He was admitted on 4/10/23. *He had diagnoses of: -Macular degeneration. -Dementia with other behavioral disturbances. *Brief interview for mental status (BIMS) score is 9 meaning moderate impairment. *Elopement risk evaluations that were completed revealed: *On admit dated 4/10/23 he was not at risk for elopement with a score of three. *On 7/8/23 following an elopement he was not at risk for elopement with a score of 4. *Elopement risk evaluation scoring/summary of risk indicated "Three or more "Resident Status/Potential Risk Factors" and/or one or more "Definitive Risk Factors" indicate a resident AT RISK for elopement." *No elopement risk evaluation was completed after 7/8/24 elopement. *The working care plan had a written elopement documented risk dated 7/18/24. 3. Review of residents (2, 3, 7, 8, 14,16, 20, 23,	F 641	(F 641 continued from previous page) System correction continued: Nursing staff were educated at nurse's meeting 8/27/24 about completing elopement assessments on all residents by the end of next week. They were also educated on our new protocol of the timeline that these will be completed going forward. The elopement assessments will be completed upon admission and then quarterly, unless the resident has an elopement at which time a new assessment would be completed and any changes at that time would be added to their care plan. Monitoring of system: audits will be completed by DON, Admin or SS on 100% of the elopement assessments for 1 month, then 50% of the elopement assessments for 3 months and then 10% of the elopement assessments for 3 months. All audit results will be reported and reviewed monthly at QAPI meetings by DON, Admin or SS.	

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F 641	Continued From page 9 25, 26, 29, 33, 41) elopement risk evaluations revealed: *They all scored three or more. *They were marked as not being at risk for elopement. 4. Review of provider's Elopement policy dated 8/2024 revealed: *"It is the policy of Sunset Manor to investigate and report all cases of missing residents off facility grounds." *"The elopement of a resident occurs when a resident has left the premises without the knowledge of a staff member." *Charge nurse will complete Incident report in Risk Management, complete detailed progress note, and complete an Elopement risk evaluation. 5. Interview on 8/7/24 at 2:40 p.m. with registered nurse (RN) F revealed: *Social service designee D would have updated the care plan for the resident in 7/2024. *A new elopement risk evaluation should have been completed by the nurse working on 7/17/24. *The stop sign on the door had been there for around six years. 6. Interview on 8/7/24 at 3:03 p.m. with minimum data set (MDS) coordinator C revealed: *The elopement should have been added to the working care plan signature sheet where changes were added, and updated. *The nurse working on 7/17/24 should have added it to the signature sheet. *Resident 43 is due for annual elopement risk evaluation in 3/2025. *She agreed resident 43 was marked wrong on the elopement risk evaluation as not being at risk for elopement.	F 641		

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F 641	Continued From page 10 *He did not have a new elopement risk evaluation completed after he eloped on 7/17/24. 7. Interview on 8/7/24 at 3:20 p.m. and 8/8/24 at 8:16 a.m. with SS designee D revealed: *She added the elopement risk to resident 43's working care plan following his elopement on 7/17/24. *Licensed practical nurse (LPN) G should have added it after the event. -She had not though it was an elopement. -She had not though it was a reportable incident. *Resident 43 had eloped from the building once before. 8. Interview on 8/8/24 at 8:22 a.m. with director of nursing (DON) B revealed: *Elopement risk evaluations were completed on admission and if an elopement occurred. 9. Interview on 8/8/24 at 9:50 a.m. with administrator A and DON B revealed: *They agreed resident 43's elopement risk evaluation was marked incorrectly as not at risk. *They expected an elopement would have been addressed in the resident's care plan. *They confirmed there was nothing in resident 43's current care plan or the EMR about being at risk for elopement. *They agreed that anyone with a score of three or more on the elopement risk evaluation should have been marked as at risk for elopement. *They were in the process of changing from American Health Tech to Point Click Care for their EMR system.	F 641		

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E 000	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 8/6/24. Sunset Manor Avera Health was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin E. Stockland

TITLE: Administrator

(X6) DATE: 08/28/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2024**

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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 8/6/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sunset Manor Avera Health was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 8/12/24. Please mark an F in the completion date column for K241 deficiencies 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 K100, K271, K522, and K911 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 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 REQUIREMENT is not met as evidenced by: Based on observation and record review, the provider failed to maintain two conforming exits	K 241		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Robin R. Stockland

TITLE
Administrator

(X6) DATE
08/28/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2024**

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) COMPLETION DATE
K 241	Continued From page 1 on each fire section of the building. One of two areas (east basement mechanical room) had only one conforming exit. Findings include: 1. Observation on 8/6/24 at 1:45 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 7/11/23 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.	K 241		
K 271 SS=C	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide a paved path of egress for one of six exits (TV lounge west exit). Findings include: 1. Observation on 8/6/24 at 1:30 p.m. revealed	K 271	K 271 System correction: We were able to find a local contractor who poured concrete for a paved pathway to the west alley on 08/27/24. No other correction needed at this time.	08/27/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2024**

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) COMPLETION DATE
K 271	Continued From page 2 the west exit discharge for the TV lounge was paved completely to the public way. The sidewalk paving stopped approximately 10 feet from the alley. Interview with the maintenance supervisor at the time of the observation confirmed that condition. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 271		
K 911 SS=C	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to perform generator maintenance as required (load bank testing) for the Kohler 500 kW diesel generator since 2020. Findings include: 1. Record review on 8/6/24 at 1:35 p.m. revealed there was no documentation the monthly load runs met or exceeded thirty percent (30%) of the generator's name plate capacity in order to avoid an annual load bank test for a diesel generator. Further record review revealed provider load test percent of load runs were last documented in 2019 and were at 19% to 20% of nameplate value. If any month in the year has a load test under 30% of nameplate value, a load bank is	K 911	K 911 System Correction: Load Bank was completed on 8/7/2024 and is now scheduled yearly with Interstate Power Systems. They will also continue to provide maintenance for our generator 2 times per year as an already contracted service. Maintenance Director will continue to do weekly checks on the generator and will maintain all documentation of weekly checks, any maintenance reports and Load Bank reports that are completed by Interstate Power Systems.	08/07/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/06/2024**

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) COMPLETION DATE
K 911	Continued From page 3 required for that year. A load bank test had last been performed in 2020 by an outside contractor. Interview with the maintenance supervisor at the time of the record review confirmed that finding. The deficiency affected one of numerous generator maintenance requirements.	K 911		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **02 - BUILDING 02** B. WING _____	**08/06/2024**

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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 8/6/24 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sunset Manor Avera Health was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K911 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 911 SS=C	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to perform generator maintenance as required (load bank testing) for the Kohler 500 kW diesel generator since 2020. Findings include: 1. Record review on 8/6/24 at 1:35 p.m. revealed there was no documentation the monthly load runs met or exceeded thirty percent (30%) of the generator's name plate capacity in order to avoid an annual load bank test for a diesel generator. Further record review revealed provider load test	K 911	K 911 System Correction: Load Bank was completed on 08/07/2024 and is now scheduled yearly with Interstate Power Systems. They will also continue to provide maintenance for our generator 2 times per year as an already contracted service. Maintenance Director will continue to do weekly checks on the generator and will maintain all documentation of weekly checks, any maintenance reports and Load Bank reports that are completed by Interstate Power Systems.	08/07/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin E. Stockland | TITLE: Administrator | (X6) DATE: 08/28/2024

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **02 - BUILDING 02** B. WING _____	**08/06/2024**

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

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K 911	Continued From page 1 percent of load runs were last documented in 2019 and were at 19% to 20% of nameplate value. If any month in the year has a load test under 30% of nameplate value, a load bank is required for that year. A load bank test had last been performed in 2020 by an outside contractor. Interview with the maintenance supervisor at the time of the record review confirmed that finding. The deficiency affected one of numerous generator maintenance requirements.	K 911		

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 _____	08/08/2024

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 8/5/24 through 8/8/24. Sunset Manor Avera Health was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/5/24 through 8/8/24. Sunset Manor Avera Health was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin E. Stockland

TITLE: Administrator

(X6) DATE: 08/28/2024