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

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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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/11/25 through 2/12/25. The areas surveyed were resident safety regarding an elopement and ingesting a chemical tablet by a resident, resident-to-resident abuse, quality of care regarding falls, and feeding assistance, and misappropriation of property. Sunset Manor Avera Health was found not in compliance with the following requirements: F684 and F689.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint, interview, interview, record review, and policy review, the provider failed to ensure dining assistance and nutritional needs were adequately care planned and implemented for one of one resident (1) with traumatic brain injury (TBI) when he refused to leave his room for meals or refused to eat. Findings include: 1. Review of the SD DOH complaint that was filed anonymously about resident 1 on 1/6/25 revealed:	F 684	F 684 Corrected to the individual: It was discovered in documentation on the hall sheets for 1/30/25 that resident #1 received his supper meal at 6:30pm and evening snack at 7:30pm. The CNA on the 6p-10p shift on the TBI on 1/30/25 documented this on the hall sheet, but had not put it in the EMR. Res #1's care plan was reviewed and updated on 3/4/25 to include the terminology that if the resident refuses a meal, the staff will save the meal for the resident and offer it to the resident again in 30 minutes and at 60 minutes. If the resident continues to refuse the meal, a house snack will be offered. Directed In-Service: Education was provided by DON & Administrator at an all-staff meeting on 3/4/25 for all licensed and unlicensed staff. Training included: -Review of 2567 from the 2/11/25-2/12/25 survey with description of the Federal tags. -Education & description of the meaning of the scope & severity of F684 SS=E & F689 SS=G. -Training provided to all licensed & unlicensed staff about their roles and responsibilities when caring for and supervising resident needs and resident safety. -Educated staff on updated "Menu Nutritional Adequacy Including Ethnic, Religious & Cultural Considerations" Policy & Procedure. (continue on next page)	03/13/2025

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

TITLE
Administrator

(X6) DATE
03/07/2025

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 684	Continued From page 1 *Resident resided in the traumatic brain injury (TBI) unit. *He had behavioral problems, such as: refusing cares, refusing to take his medications, refusing to come out of his room for meals, refusing to eat. *When residents who required assistance would not come out of their rooms, they were not allowed to have a meal tray in their room. *Two to three weeks prior to filing the complaint, resident 1 had gone without his evening meal for three consecutive nights due to him not coming out of his room. *Resident 1 required assistance with eating. 2. Observation on 2/11/25 at 11:45 a.m. of resident 1 while eating his noon meal revealed: *Resident 1 was in the dining area with his spouse and other residents who were sitting in the area. *Resident 1's spouse was assisting him in eating his meal. *Resident 1 was dependent on his spouse to help him eat his meal. 3. Interview on 2/11/25 at 1:30 p.m. with resident 1's spouse revealed: *"He has been here for over a year." *She felt there was a lot of staff turnover and a lack of staff on duty during the nighttime. *She was concerned about him not receiving meals at night. -She reported that a certified nursing assistant (CNA) (she was unable to recall the CNA's name) told her if resident 1 did not come out of his room for meals, he would not eat because there were no extra staff to help him eat. *She reported some of the CNAs were not trained to care for residents with traumatic brain injuries.	F 684	F 684 Directed In-Service continued: -Educated nursing staff on documentation of all meal refusals and if the resident chooses to eat later, what should be documented. Educated nursing on the updated hall sheets that CNAs carry and turn into the charge nurse at the end of their shift. There is an updated section for meals/intake/refusals that has been added for more detail. All staff who were not able to attend the all-staff meeting on 3/4/25, are required to complete the training with DON or designee no later than 3/13/25. System correction: Medical Director was in the facility on 2/11/25 and was notified that the surveyors were in house for complaint surveys. The medical director is in agreement with the changes that have been made to the hall sheets and to the updated "Menu Nutritional Adequacy Including Ethnic, Religious & Cultural Considerations" policy & procedure. Hall sheets have been updated for all CBU and TBI residents to include the added meal/intake/refusal section as of 3/4/25. There are now three places for CBU & TBI staff to document meals (PCC, meal intake sheets and hall sheets). The "Menu Nutritional Adequacy Including Ethnic, Religious & Cultural Considerations" policy & procedure has been updated as of 3/4/25 to include a section on resident refusal of a meal and proper procedure to follow to ensure the resident is getting adequate nutrition, and for residents requiring assistance with meals to be highly encouraged to eat in the dining room, but if they refuse that staff will assist them in their room. All care plans have been updated to reflect a resident's preferences for meals, if they require staff assistance and any adaptive equipment needed. Monitoring of system: Audits will be completed of meal intake on the TBI by the DON, CDM or designee on a weekly basis for 4 weeks, then every other week for 2 months, then monthly for 3 months to ensure proper documentation of all meals/refusals/intakes are completed and followed up on. This will include auditing documentation on hall sheets and EMR. (continue on next page)	

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F 684	Continued From page 2 *She felt some of the CNAs did not understand that it took resident 1 more time to process what was said to him, and the CNAs would get frustrated with him. 4. Interview on 2/12/25 at 9:10 a.m. with CNA G revealed: *She was a traveling CNA and had worked at the facility for about three years. *There was no specific or extra training required to work in the challenging behavior unit (CBU) or TBI units. *She confirmed that resident 1 required assistance with eating. *CNAs are oriented in all three units because they can be assigned to work anywhere in the facility. *If residents who required assistance with eating did not come out of their rooms for a meal, there was no one available to assist them with eating in their rooms. 5. Interview on 2/12/25 at 11:57 a.m. with director of nursing (DON) B revealed: *There was no specific training provided for CNAs that worked on the CBU or TBI units. -"We want our CNAs to be able to work on any unit at any time." *Resident 1 would sometimes eat in his room with assistance by his spouse. *Resident 1's spouse visited him nearly every day during the noon meal and would assist him with eating. *Resident 1 was not allowed to eat alone in his room due to his difficulty with swallowing. *She reported if resident 1 did not want to come out of his room at the time of the evening meal, staff should attempt to have him come out to the dining area later to eat, offer him snacks later, and document that.	F 684	F 684 Monitoring of system continued: All results will be reported to the QAPI team at monthly QAPI meetings by DON, CDM or designee.	

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F 684	Continued From page 3 *It was her expectation resident 1 would be assisted with eating in his room. *It was her expectation that if resident 1 refused to eat his meals in the dining room several nights consecutively, it would be noted in the progress notes. *Documentation of meals was to be recorded three times per day and as needed (PRN). *She reported the PRN documentation would be for afternoon or evening snacks. 6. Review of the resident's care plan revealed there was no specific instruction on the amount of eating assistance he needed from staff during meals. *His care plan did not indicate if he could or could not eat in his room. 7. Review of resident 1's electronic medical record (EMR) revealed: *Documentation of his meals and snacks from 1/14/25 through the morning of 2/12/25 indicated: -On two of 30 days, meals and/or snacks intakes were documented four times each day. -On 22 of 30 days, meals and/or snacks intakes were documented three times each day. -On five of 30 days, meals and/or snacks intakes were documented two times each day. -On seven of 30 days, it was documented resident 1 refused his evening meal (1/14, 1/19, 1/28, 1/29, 1/30, 2/1, and 2/8/25). *His progress notes did not indicate why resident 1 had not received meals and/or snacks, or if meals or snacks had been offered between scheduled meals. 8. Review of the provider's 11/2020 "Resident Right-Nursing Home" booklet given to residents on admission revealed:	F 684		

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F 684	Continued From page 4 *Page 3: "All nursing homes are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care." *Page 5: "Right to dignity, respect, and freedom: Be treated with consideration, respect, and dignity."	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review the provider failed to ensure the safety of one of one sampled resident (2) with cognitive impairment who ingested an improperly stored and secured Santimine (sanitizing chemical) tablet. Findings include: 1. Review of the provider's 2/6/25 SD DOH FRI regarding resident 2 revealed: *His Brief Interview for Mental Status (BIMS) assessment score was 1 which indicated he had severe cognitive impairment. *On 2/6/25 at 1:50 p.m. he was observed raising his hand to his mouth and a blue coloration was noted in his mouth.	F 689	F 689 After receiving the 2567 and looking at the chemicals, it was discovered that the incorrect chemical name had been reported on the FRI. The chemical in question was Steramine instead of Santamine. Santamine and Steramine have similar/same side effects and treatment recommendations. Resident #2 did not have any side effects or any issues from the incident. Corrected to the individual: Res #2 is currently a 1:1 with staff and care plan has been updated with more specifics of what the 1:1 staff is to do with/for the resident to keep Res #2 safe and free from hazards. More activities have been integrated into the specialty unit where Res #2 resides in order to keep all residents occupied with more leisure activities. Directed In-Service: Education was provided by DON & Administrator at an all-staff meeting on 3/4/25 for all licensed and unlicensed staff. Training include: -Review of 2567 from 2/11/25-2/12/25 survey with description of the Federal tags received. -Education & description of the meaning of the scope & severity of F684 SS=E & F689 SS=G. -Training provided to all licensed & unlicensed staff about their roles and responsibilities when caring for and supervising resident needs and resident safety. -Educated all staff on keeping all chemicals locked up and to lock all cupboard/closet doors, storage room doors, tub house and public bathrooms to ensure residents are not able to get into any chemicals. -Educated all staff that there will no longer be Steramine tablets on the CBU. CBU staff will (continue on next page)	03/13/2025

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F 689	Continued From page 5 *A unnamed certified nursing assistant (CNA) asked him to spit it out which he. *Unnamed CNAs approached him and noted they were Santimine (sanitizer tablets). *He went to put another tablet in his mouth, and registered nurse RN C swatted it out of his hand causing it to fall to the floor. *Material safety data sheets (MSDS) were pulled. *Poison control was called. *Medical director (MD) J was notified. -Due to increased behaviors and agitation, he was given Haldol 5 mg intramuscularly (IM). -Immediate medical intervention was to push fluids, not to induce vomiting, and to monitor. -He was given diluted orange juice. *His vital signs were taken. -Blood pressure 121/74: -Temperature 98.1. -Pulse 105. -Respirations 18. -Oxygen saturation on room air was 94%. 2. Review of resident 2's electronic medical record (EMR) revealed: *He had diagnoses of: -Chronic obstructive pulmonary disease (a disease that blocks airflow making it difficult to breathe). -Dementia (memory loss) with behavioral disturbances and agitation. -Epilepsy (seizure disorder). -Age-related bilateral cataract (clouding of the eye lens). -Presbyopia (far-sightedness). *His care plan indicated: -"Offer me 1:1 (staff monitoring), redirect me back to my room to watch tv, or to play checkers." -"Staff to monitor me (resident 2) closely ..." -"Staff will monitor me for going into other	F 689	F 689 Directed In-Service continued: go to the kitchen for a bucket of sanitizer water after each meal to wash the tables. Staff will return the bucket back to the kitchen when they are finished washing the tables. All staff who were not able to attend the all-staff meeting on 3/4/25, are required to complete the training with DON or designee no later than 3/13/25. System correction: Steramine tablets have been removed from the unit so there is no chance of them being left out or for them to be in an unlocked cupboard or drawer where residents could potentially get into them. Staff will now be going to the kitchen for a bucket of sanitizer water after each meal to wipe/sanitize the tables and then return the bucket back to the kitchen after each meal. More activities have been integrated in the CBU to get residents more involved with leisure skills to hopefully decrease behaviors. Monitoring of system: Audits will be completed of chemicals and locks on the CBU by DON or designee 2 x per week for 4 weeks, then weekly for 4 weeks, then every other week for 2 months, then monthly for 3 months to ensure all doors are locked and there are no chemicals in view of residents or any they are able to access. All results will be reported to the QAPI team at monthly QAPI meets by DON or designee.	

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F 689	Continued From page 6 resident rooms ..." *It was documented in his medication administration record for 2/6/25 that he had refused all of his morning medications that day. 3. Interview on 2/11/25 at 1:40 p.m. with RN C revealed: *There were two CNAs working in the Challenging Behaviors Unit (CBU) at the time of the above incident. Resident 2 was yelling at CNA H, while CNA K was helping another resident in the bathroom. *Resident 2 had a Santimine tablet in his mouth. *They asked him to spit it out, which he did. *Resident 2 tried to place another Santimine tablet in his mouth and she moved his hand away from his mouth. *Santimine tablets were supposed to be locked up. *Resident 2 found them in an unlocked drawer behind resident clothing protectors. 4. Interview on 2/11/25 at 2:15 p.m. with CNA H regarding the above incident revealed: *Resident 2 was on close, 1:1 monitoring. *CNA K had taken another resident to the bathroom. *CNA H had her back to resident 2. *Resident 2 was observed by CNA K near the kitchenette in the CBU after exiting the bathroom. -She asked resident 2 what he had in his hand. *RN C entered the CBU and noticed resident 2 had something in his mouth. -RN C asked him to spit it out, which he did. It was a Santimine tablet. -He then tried to put another tablet in his mouth and RN C swatted it out of his hand. *CNA H thought CNA F had put a bottle of the tablets in a drawer that was not locked.	F 689		

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F 689	Continued From page 7 *Santimine tablets were supposed to be locked up. 5. Interview on 2/11/25 at 3:05 p.m. with CNA K regarding the above incident revealed: * She observed resident 2 was leaving the kitchenette area and had something in his mouth. *RN C entered the CBU and asked him to spit it out and he did. *He then tried to put another Santimine tablet in his mouth before it was taken away. *They gave him extra fluids after that incident. *Santimine tablets were supposed to be locked up. 6. Interview on 2/11/25 at 3:10 p.m. with RN C revealed: *She pulled the MSDS information on Santimine tablets. *DON B called poison control she believed and notified MD J of the incident with resident 2. 7. Interview on 2/11/25 at 3:35 p.m. with CNA F revealed: *He had worked the 2/5/25 night shift and left on 2/6/25 at 6:00 a.m. *Before leaving he had used the Santimine tablets to make a bucket of cleaner. *He had placed the Santimine tablet bottle in an unlocked drawer by the sink before he left. *That drawer lock had been broken for some time. *The locks had been fixed on 2/11/25. *He was aware that Santimine tablets should have been locked up. *Santimine tablets had been pulled from the CBU and were not being used. 8. Interview on 2/12/25 at 11:15 a.m. with DON B	F 689		

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F 689	Continued From page 8 revealed: *She was alerted by RN C about the above incident. *RN C had pulled and referred to the sanitizer's MSDS. *RN/Unit Coordinator (UC) L had contacted the poison control center. *DON B had notified MD J of the above incident. - An order was received for resident 2 to be given Haldol (An antipsychotic) 5 mg IM for behaviors and it was given. *Administrator A was notified of the above. *An investigation was started. *An incident report was completed. *The SD DOH FRI report was completed. *She explained 1:1 monitoring for resident 2 meant staff were: -To be within arm's length of him between 6:00 a.m. and 10:00 p.m. -That 1:1 monitoring had increased his behaviors, so they would give him a little space and intervene when needed. -She expected staff to not turn their back on resident 2. *There was a notice dated 2/3/25 in the CBU: -"We will be adding a third staff for CBU from 6:00 a.m. to 10:00 p.m." -"You should remain in the common area within reach of resident 2 at all times to prevent any assaults from occurring." -"There must be two staff present on the unit, at all times. One staff member must be monitoring resident 2/common areas at all times. If this means your nurse needs to come out call them, If this means you need [RN/UC L], or [DON B], call us." *Locks have been replaced. *Verbal education was provided to staff working in the CBU.	F 689		

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F 689	Continued From page 9 *Santimine tablets were removed, from the CBU temporarily, until the locks have been replaced. Review of the providers revised 4/2023 Hazardous Materials and Waste Management Plan policy revealed: *"To recognize the potential threat that hazardous materials present to human health and the environment. To establish, implement, monitor and document evidence of an ongoing program for the management of hazardous materials and waste to ensure that there is minimal risk to patients, personnel, visitors and the community environment within the confines of the ASHH campus. The processes include education, procedures for safe use, storage and disposal, and the management of spills and exposure." *"Providing adequate and appropriate space and equipment for safe handling and storage of hazardous materials and wastes: All storage areas have spaces appropriate for storage regarding space requirements and are under lock and key to provide safe segregation from other work areas."	F 689		