

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435100</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  <b>05/05/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>Sunset Manor Avera Health</b>			STREET ADDRESS, CITY, STATE, ZIP CODE  <b>129 E CLAY ST , IRENE, South Dakota, 57037</b>	
(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/4/26 through 5/5/26. Areas surveyed included suspicion/allegation of abuse/neglect and physical harm/injury. Sunset Manor Avera Health was found not in compliance with the following requirements: F600 and F609.	F0000		
F0600 SS = G	Free from Abuse and Neglect  CFR(s): 483.12(a)(1)  §483.12 Freedom from Abuse, Neglect, and Exploitation  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.  §483.12(a) The facility must-  §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;  This REQUIREMENT is NOT MET as evidenced by:  Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, interview, and policy review the provider failed to protect the residents' right to be free from physical abuse for one of one sampled resident (1) who was straddled and restrained in his bed by one of one certified nursing assistant (CNA)G while he provided incontinence (involuntary urine and bowel leakage) care to resident 1.  Findings include:	F0600	F0600  System Correction: All nursing staff will be re-educated on incident reporting and the requirement for reporting to the state through the Facility Reporting Incidents no later than 6/3/26. Education will include information from the 2567, a review of the State Reporting Policy, Incident Reporting Policy and Investigation Policy, and LTC Abuse Prohibition Policy. These policies will be reviewed by all Nursing staff. Nursing staff will also be educated on their responsibility to assure a staff member suspected of abuse is suspended and not allowed to continue to work until a full investigation is completed. CNA and Nurses meetings will be held on 5/27/26 with all education completed with any remaining staff by 6/3/26.  All staff meeting will be conducted on 5/27/26 to provide information from the 2567 and re-education on the LTC Abuse Prohibition policy as well as the incident investigation form that is required to be filled out if they are a witness to any residents or those with behaviors. Education will be provided on ideas on how to redirect residents and examples of interventions. Education will also be provided at the all staff meeting and both CNA and nurses meetings reminding staff they are all mandatory reporters and if they have any concerns about resident cares or resident safety they need to report it immediately to their supervisor, Social Services, DON or administrator. Any staff not present at the all staff meeting on 5/27/26 will be educated by 6/3/26.  (Continued on next page)	06/03/2026

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  <i>Robin R. Stockland</i>	TITLE  <b>Administrator</b>	(X6) DATE  <b>05/27/2026</b>
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F0600 SS = G	<p>Continued from page 1</p> <p>1. Review of the provider's SD DOH FRI report dated 3/23/26 revealed that resident 1 had a Brief Interview for Mental Status (BIMS) assessment score of 99, which indicated his cognition was severely impaired. The report indicated that on 3/22/26 at 4:00 a.m., resident 1 became combative during incontinence care provided by CNA G. During the interaction, CNA G straddled resident 1 in his bed to manage the resident's combative behavior and applied pressure with his thumb to a pressure point behind the resident's ear to calm the resident. This action increased the resident's combative response, and CNA G provided incontinent care while the resident was restrained.</p> <p>2. Review of resident 1's electronic medical record (EMR) revealed he was admitted to the facility on 8/13/24. His diagnoses included neurocognitive disorder with Lewy Bodies (progressive brain disorder characterized by abnormal protein deposits that cause cognitive decline, visual hallucinations, movement issues, and fluctuating alertness), dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances and anxiety (anticipation of future changes or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). His care plan indicated he had memory problems and became confused easily, and staff were to encourage and assist him in making safe decisions regarding his care and personal relationships by giving him safe and simple choices. He wore incontinent products (briefs) for dignity and protection, and staff were to assist him with incontinent care with each incontinent episode.</p> <p>3. Observation on 5/5/26 at 10:15 a.m. of resident 1 revealed he was asleep in his bed and unable to be interviewed.</p> <p>4. Interview on 5/5/26 at 10:10 a.m. with director of nursing (DON) B revealed that CNA G reported the incident to licensed practical nurse (LPN) C at approximately 6:00 a.m. on 3/22/26 during the morning shift report (the communication given by the staff who are ending their shift to the incoming staff before the new shift begins. It includes essential information about each patient's current status, recent changes, important events from the previous shift, ongoing concerns, and tasks that need follow-up. The purpose is to ensure continuity of care, maintain patient safety, and keep the</p>	F0600	<p>(F0600 Continued from page 1)</p> <p>Corrected to Individual: CNA G was suspended on 3/23/26 as soon as DON &amp; Admin were notified of the incident. CNA G was then terminated on 3/25/26 for abuse of resident. CNA G was also reported to the SD Board of Nursing (SDBON) and to Clay County Sheriff's department where charges are pending. NM E was suspended on 3/23/26 when DON &amp; Admin were notified of the incident and then terminated on 3/24/26 for failure to report abuse of a resident and allowing CNA G to report to work. MDS Nurse F was suspended on 3/23/26 when DON &amp; Admin were notified of the incident and then terminated on 3/25/26 for failure to report abuse of a resident and allowing CNA G to report to work. Both nurses, NM E and MDS F were also reported to the SDBON</p> <p>Ongoing education with nursing staff on Mandatory reporting requirements and above policies. Medical Director, Tyler Hanson, MD and Board of Directors have approved the PoC as of 5/27/2026.</p> <p>Monitoring of system: DON, Admin or designee will monitor 50% of incident reports to determine if State Reports (FRIs) have been completed when necessary and that the FRIs where required were initiated in a timely manner. Audits will be completed 2x week x 4 weeks, 1x week x 4 weeks, monthly x 4 months. Information for all audits will be reported to QAPI team at monthly QAPI meetings by DON, Admin or designee.</p>	

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F0600 SS = G	<p>Continued from page 2 oncoming staff fully informed).</p> <p>LPN C then reported the incident to nurse manager (NM) E, who subsequently notified the minimum data set (MDS) nurse F. CNA G returned for his scheduled night shift on 3/23/26 and provided direct resident care.</p> <p>MDS nurse F reported the incident to administrator A and DON B on 3/23/26 through the FRI reporting process and an email. DON B suspended CNA G on 3/23/26 pending the outcome of the facility's investigation. During the investigation, DON B interviewed LPN C, NM E, and MDS nurse F, who confirmed that the interaction between CNA G and resident 1 was reported by CNA G. DON B ensured the resident's medical provider and representative were notified of the incident.</p> <p>5. Interview on 5/5/26 at 1:41 p.m. with LPN C revealed that on 3/22/26, around 6:00 a.m. CNA G indicated that resident 1 was combative while he provided his care. CNA G used the term "straddle the resident" when he described how he managed the resident's behavior when he cleaned stool from the resident's perineal area (the region of the body between the thighs, including the area from the genitals to the anus). He also reported that he had placed pressure behind the resident's ear to distract him when he completed the care. LPN C assessed the resident and did not find any injuries on resident 1's body.</p> <p>She reported the information to her supervisors, NM E, and MDS nurse F, both of whom were in the facility after she had received the report. LPN C stated this was the first time she had heard of an incident of this nature and now understands she was required to notify the DON and complete a report to the SD DOH.</p> <p>6. Interview on 5/5/26 at 3:08 p.m. with CNAs D and H revealed they each had received training on abuse and neglect, resident rights, and dementia care. CNA H indicated that she had a criminal background check completed, and she had to sign an abuse affidavit before she was allowed to work at the facility. CNA H and CNA D indicated they had no concerns regarding any staff member regarding abuse or neglect. They denied any family members sharing a concern, such as abuse to her, but indicated they would go to their DON or nurse if there was a concern.</p>	F0600		

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F0600 SS = G	Continued from page 3  7. Review of NM E's personnel file revealed she was placed on leave on 3/23/26, and her employment with the facility was terminated on 3/24/26. She received annual training on 9/11/25 and 9/15/25 that included abuse and neglect, resident rights, and dementia care. An abuse affidavit was completed when she was hired, and a criminal background check was completed that had no remarkable findings.  8. Review of MDS nurse F's personnel file revealed she was placed on leave on 3/23/26, and her employment with the facility was terminated on 3/25/26. She received annual training on 9/8/25 that included abuse and neglect, resident rights, and dementia care. An abuse affidavit was completed when she was hired, and a criminal background check was completed that had no remarkable findings.  9. Review of CNA G's personnel file revealed he was hired on 9/25/25 and his employment with the facility was terminated on 3/25/26. He received training on 9/25/25 that included abuse and neglect, resident rights, and dementia care. An abuse affidavit was completed when he was hired, and a criminal background check was completed that had no remarkable findings.  10. Review of the provider's January 2024 Long Term Care Abuse Prohibition Policy revealed, "It is essential for facilities to prohibit and prevent abuse, neglect, exploitation of residents, misappropriation of resident property, corporal punishment, and involuntary seclusion, including freedom from physical or chemical restraints not required to treat a resident's medical symptoms. The facility will have systems in place to encourage and support all residents, staff, families, visitors, and resident representatives in reporting any suspected acts of abuse, neglect, or exploitation of residents, misappropriation of resident property, corporal punishment, and involuntary seclusion. The term "abuse" (indicates any type of abuse, i.e., sexual abuse, staff to resident, resident to resident, visitor to resident, physical, mental, verbal, deprivation of goods and services, neglect, exploitation, involuntary seclusion, misappropriation of resident property, and corporal punishment) will be used throughout this policy unless specifically indicated."	F0600		

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F0600 SS = G	<p>Continued from page 4</p> <p>"An owner, licensee, administrator, manager, employee, agent, contractor, or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or neglect a resident."</p> <p>"All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator."</p> <p>"All owners, operators, employees, managers, agents, or contractors must report to the State Agency and one or more law enforcement entities any reasonable suspicion of a crime against an individual who is a resident of or is receiving care from the facility."</p> <p>"No later than 24-hours if the event did not result in serious bodily injury."</p> <p>"Abuse: "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish."</p> <p>"Physical abuse "includes, but is not limited to, hitting, slapping, pinching, and kicking."</p> <p>"Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object."</p> <p>"Convenience: is defined as the result of any action that has the effect of altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest."</p> <p>"Freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control."</p> <p>"Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria,</p>	F0600		

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F0600 SS = G	Continued from page 5 cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body."	F0600		
F0609 SS = D	Reporting of Alleged Violations  CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.  This REQUIREMENT is NOT MET as evidenced by:  Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, and policy review, the provider failed to report a physical abuse incident to the SD DOH within the required time frame for one of one sampled resident (1), who was straddled and restrained in his bed by one of one certified nursing assistant (CNA) (G) while he provided incontinence (involuntary urine and bowel leakage) care to resident 1.  Findings include:  Findings include:	F0609	F0609  System Correction: All nursing staff will be re-educated on incident reporting and the requirement for reporting to the state through the Facility Reporting Incidents no later than 6/3/26. Education will include information from the 2567, a review of the State Reporting Policy, Incident Reporting Policy and Investigation Policy, and LTC Abuse Prohibition Policy. Nursing staff will also be educated on their responsibility to assure a staff member suspected of abuse is suspended and not allowed to continue to work until a full investigation is completed. Additional education will be done with all nurses reminding them of their mandatory reporting status and the need for them to report any concerns for resident safety or resident cares to their supervisor, DON, Social Services or Admin immediately. Nurses meeting will be held 5/27/26 with any education completed with any remaining staff by 6/3/26.  Corrected to individual: NM E was suspended on 3/23/26 and then terminated on 3/24/26 for failure to report abuse of a resident and allowing CNA G to report to work. MDS Nurse F was suspended on 3/23/26 and then terminated on 3/25/26 for failure to report abuse of a resident and allowing CNA G to report to work. All 3 staff members above were reported to the SDBON and CNA G was reported to the Clay County Sheriff with charges pending.  Ongoing education with nursing staff on Mandatory reporting requirements and above policies. Medical Director, Tyler Hanson, MD and Board of Directors have approved the PoC as of 5/27/2026.  Monitoring of system: DON, Admin or designee will monitor 50% of incident reports to determine if a FRI has been completed when necessary and that the FRI was initiated in a timely manner. Audits will be completed 2x week x 4 weeks, 1x week x 4 weeks, monthly x 4 months. Information for all audits will be reported to QAPI team at monthly QAPI meetings by DON, Admin or designee.	06/03/2026

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F0609 SS = D	<p>Continued from page 6</p> <p>1. Review of the provider's 3/23/26 SD DOH FRI (a required reporting of unexpected or adverse events) report revealed that on 3/22/26 at 4:00 a.m., resident 1 was combative during morning care rounds (changing of residents who were incontinent of stool or urine). CNA G had turned the resident so he was positioned on his side, lying in his bed. That increased the resident's combative behavior, so CNA G placed a leg over the resident to straddle him. CNA G then used his thumb and put pressure on a pressure point under the resident's ear (to lock the resident's jaw) to distract the resident. This increased resident 1's combative behavior, but allowed CNA G to complete the incontinence care for resident 1.</p> <p>CNA G reported this incident to licensed practical nurse (LPN) C at 6:00 a.m. on 3/22/26 during the morning shift report (report to the oncoming staff about resident care). LPN C reported the incident to nurse manager (NM) E, who then reported it to the minimum data set (MDS) nurse F. An incident report was completed by LPN C on 3/22/26 and placed under DON B's office door. The incident occurred over the weekend, and DON B was not in the facility. LPN C asked MDS nurse F if DON B should be called to notify her of the incident. She was told by MDS nurse F that an email was sent to DON B. The email was sent by MDS nurse F to DON B on 3/22/26 at 2:52 p.m., before she had left for the day.</p> <p>CNA G returned to work on 3/23/26 for his next scheduled night shift and provided direct contact care for the residents.</p> <p>2. Interview on 5/5/26 at 10:10 a.m. with DON B revealed on 3/23/26, she became aware of the alleged abuse incident that involved resident 1 and CNA G. She indicated the incident occurred on 3/22/26 at 4:00 a.m. during the resident's morning incontinence cares, and CNA G reported it to LPN C before he left the facility after his scheduled shift. DON B had indicated that the incident had not been reported to the SD DOH in the required time frame.</p> <p>DON B stated resident 1 was combative when CNA G was providing resident 1's incontinence care. CNA G had stated he straddled the resident in the resident's bed to hold him down so he could clean</p>	F0609		

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F0609 SS = D	<p>Continued from page 7 stool from the resident's perineal area (the region of the body between the thighs, including the area from the genitals to the anus).</p> <p>Resident 1 remained combative with CNA G, so CNA G put pressure on a pressure point area behind the resident's ear to distract him from moving. CNA G returned to work on 3/23/26 for his scheduled night shift, since the incident was not reported to the DON B or administrator A as it should have been.</p> <p>She completed the incident reporting to the SD DOH on 3/23/26, but she did not report the incident to the Department of Human Services (DHS). She indicated that there were previous incidents involving other residents that she had reported to DHS, but she never heard back from the DHS, or if she did, they told her they were not concerned because the resident was in a safe place.</p> <p>3. Interview on 5/5/26 at 1:41 p.m. with LPN C revealed on 3/23/06 at 6:00 a.m., during morning report with CNA G, he reported he had straddled resident 1 during his incontinence cares because the resident was being combative. CNA G told her he then used his thumb to put pressure on a pressure point behind the resident's ear to calm him down. CNA G indicated that the resident became more combative after he had done that, but he was able to get the job done.</p> <p>She assessed resident 1 after receiving the report of the incident from CNA G, and no injuries were found on resident 1's body.</p> <p>She reported the incident to NM E, who then reported the incident to the MDS nurse F, as she was the management nurse that day. LPN C had asked NM E and MDS nurse F if CNA G should return for his scheduled night shift on 3/23/26. She indicated that both NM E and MDS nurse F reported that they had filled out an incident report, placed it under DON B's office door, and sent her an email to inform her of the incident.</p> <p>4. Interview on 5/5/26 at 1:08 p.m. with DON B revealed she expected that if an alleged violation involving resident abuse or neglect occurred, she would be notified immediately.</p>	F0609		

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F0609 SS = D	<p>Continued from page 8</p> <p>5. Review of the provider's 1/2024 Long Term Care Abuse Prohibition Policy revealed, "It is the policy of the facility that abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion allegations are reported according to Federal and State Laws. The facility will ensure that all alleged violations involving abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion are reported immediately to the administrator."</p> <p>"All alleged violations of abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion must also be reported by the facility to officials in accordance with State law, including the State Survey Agency and adult protective services where State law provides for jurisdiction in long-term care facilities."</p> <p>"Immediately, but no later than 2 hours if the alleged violation involves abuse or results in serious bodily injury."</p> <p>"Facility initial reporting of allegations: For all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, the administrator or designee will notify officials in accordance with State law, to include the State Survey Agency and adult protect services where state law provides for jurisdiction in long-term care facilities immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury or no later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury."</p> <p>"Department of Human Services (DHS) Notification: only for an incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person."</p>	F0609		