

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 <i>*Addendums noted with an asterisk per 5/19/16 per telephone with facility DON. JT/SDDOHTEL</i>	F 000		
F 226 SS=E	Surveyor: 32331 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/4/16 through 4/6/16. Sunset Manor Avera Health was found not in compliance with the following requirements: F226, F246, F283, F364, F425, F441, F468, and F514. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review, interview, and policy review, the provider failed to follow their investigation policy and thoroughly investigate four of four falls for one of seven sampled residents (8). Findings include: 1. Review of resident 8's progress notes from 11/2/15 through 4/5/16 revealed: *He had fallen on 12/30/15, 2/5/16, 2/25/16, and 3/27/16. *The 12/30/15 note stated "[Certified nursing assistant (CNA) name] informed recorder that [name of resident] had fallen while she was assisting him with a transfer from toilet to wheelchair. Informs recorder he did not hit his head, and was eased to the floor. Resident has	F 226	F 226-We plan to IDR this tag. Correct to the individual: System change will correct the cited deficiency. Resident 8 documentation was reviewed due to the date of the documentation, no further changes could be made. Correct to all others: All of the nursing staff will be educated on the correct procedure in completing the investigation checklist for documentation on incident reports. A fall huddle with the nursing staff will be implemented for each fall going forward as well. Education was done on 4/21/16. System correction: Investigation checklist has been added to the procedure of investigating all incidents. The fall follow up documentation will be done in a nursing note. Audits will be completed 2 times per week for 4 weeks, weekly for 4 weeks and then monthly for 4 months. Audits will be completed by DNS, or designee. <i>*On all incidents including falls. JT/SDDOHTEL</i> Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. DNS or designee will be responsible for reporting all audits to the QAPI team for review and appropriate recommendations.	5/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Adm. Director

(X6) DATE

4-27-16

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	<p>Continued From page 1</p> <p>left side weakness but is able to bear weight on left leg. Left arm is flaccid. Resident did complain his left shoulder "hurts a little bit." No visual bumps, bruises, cuts, abrasions, or open areas. Denies hitting head."</p> <p>*The 2/5/16 note stated "Was called to residents room by CNA staff. Noted resident to be laying on the floor next to his wheelchair on his right side. Resident did complain of right shoulder pain. Did state he hit his head. Noted abrasion to his right knee approximately quarter size in diameter. Has right sided weakness."</p> <p>*The 2/25/16 note stated "Resident tried to self transfer himself on to the toilet in his room and fell against the adjoining door and slid to the floor. He stated that he did not injure anything and has no pain."</p> <p>*The 3/27/16 note stated "When ambulating the resident with his hemi walker he co [complained] of back pain after few steps and he tries to sit with no chair behind him."</p> <p>*There was no documentation in the progress notes regarding investigations into the above mentioned falls.</p> <p>Interview on 4/6/16 at random times from 2:00 p.m. through 6:00 p.m. with the administrator, director of nursing, and licensed social worker regarding the above falls for resident 8 revealed the investigations into those falls were done on an internal document. They were not required to share those internal documents with the survey team. They had no other documentation to confirm they had investigated those above mentioned falls. They had gone through the process for the 12/30/15 fall but had not included documentation regarding if the CNA had used the gait belt or if the care plan had been followed. They had not provided any other investigation</p>	F 226			

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 226	Continued From page 2 documentation regarding the falls on 2/5/16, 2/25/16, or 3/27/16. Review of the provider's March 2016 Abuse Prohibition policy revealed: **Clear concise documentation of indisputable evidence is critical for protection of the resident. *Document also in the resident chart, including both the resident and the caregivers explanation of what occurred. *The administration will complete a thorough investigation of the incident, including interviews with staff, residents and family as appropriate and complete a written report of these findings. *All completed investigate reports and documentation will be kept on file."	F 226			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, interview, and admission packet review, the provider failed to ensure a food request was given to one of three sampled residents (10) and to place one of three sampled residents (7) facing towards the table during meal service in the challenging behavior unit (CBU). Findings include:	F 246	F 246 Correct to the individual: Resident 7's seating arrangement has been changed while at dining table. Resident 10's food requests are being followed through with and documented in nursing notes. Correct to all others: Education was given to nursing department on resident rights, dignity and food request documentation on 4/21/16. System correction: Dining room seating arrangement was changed to be more accommodating to all residents. All resident food requests outside of scheduled meal times are being	5/26/16	

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016	
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 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 246	<p>Continued From page 3</p> <p>1. Observation on 4/4/16 at 4:40 p.m. of resident 10 revealed he was sitting in his wheelchair in the living room hitting and scratching at his head.</p> <p>Interview at that time with an unidentified certified nursing assistant revealed he had asked for a sandwich, but since it was so close to supper they had not gotten him one. She stated he would hit his head and scratch at his head when he did not get his way.</p> <p>Observation on 4/4/16 from 5:05 p.m. through 5:20 p.m. of resident 10 revealed he was served his food at 5:05 p.m. He had not received a sandwich for supper. He had not eaten anything off his plate.</p> <p>Interview on 4/4/16 at 5:20 p.m. with registered nurse B regarding resident 10 revealed he liked sandwiches. That was all he would eat if they would let him and they only allowed him to have one per day. Sometimes they would use it with his medications as he would refuse to take his medications. If they offered him a sandwich he would then take his medications.</p> <p>Review of the weight change report provided by the dietary manager revealed resident 10 had lost 2.5 pounds from 10/31/15 through 2/3/16. On 2/3/16 he weighed 104.5 pounds.</p> <p>Interview on 4/6/16 at 5:00 p.m. with the director of nursing (DON) and the CBU coordinator revealed they should have given him a sandwich for supper if that was what he requested.</p> <p>2. Observation on 4/4/16 at 5:00 p.m. of resident 7 revealed she had been placed at the table</p>	F 246	<p>documented. Audits will be completed weekly times 4 weeks, monthly times 4 months by DNS or designee. <i>*and those audits will be done at random meals for all residents requiring assistance at meals and at random Monitoring of System. times of residents specific</i></p> <p>The results of the audits will be reviewed at the monthly QAPI meetings with updates <i>food requests outside of scheduled meal times.</i> made as needed. The DNS or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.</p> <p style="text-align: right;"><i>JT/SDDCH/L</i></p>	

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 246	<p>Continued From page 4</p> <p>backwards and was facing away from the other residents.</p> <p>Observation on 4/5/16 at 12:00 noon of resident 7 revealed she had been placed at the table facing the other residents.</p> <p>Interview on 4/5/16 at 12:00 noon with certified nursing assistants (CNA) G and H revealed they placed her facing the other residents at meal time. That was so she had the same dining experience as the other residents. They turned off the television in the living room, so there was no distraction for her.</p> <p>Observation on 4/5/16 at 5:15 p.m. of resident 7 revealed she had been placed backwards facing away from the other residents in the dining room. The television was on, and the activities staff person was sitting in the living room working at a bedside table in the resident's line of sight. She had started to holler. The activities staff then turned on a different picture on the television.</p> <p>Interview on 4/6/16 at 5:00 p.m. with the DON and the CBU coordinator revealed it was not care planned for her to be placed backwards and facing away from the other residents. They were unsure as to why staff would be doing it different at each meal.</p> <p>3. Review of the provider's Resident Rights and Responsibilities handbook provided at admission revealed "The resident has the right to choose activities, schedules, and health care consistent with their interests, assessments, and care plans; to interact with members of the community and make choices about aspects of their life at [facility name] that is significant to the resident."</p>	F 246			

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 283 SS=D	<p>483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Based on record review and interview, the provider failed to ensure one of one discharged resident (13) had a recapitulation (recap) (summary of stay) documented. Findings include:</p> <p>1. Review of resident 13's medical record revealed: *She had been discharged to another long term care facility on 10/29/15. *There was no documentation a recap of her stay had been completed.</p> <p>Interview on 4/6/16 at 4:00 p.m. with the director of nursing (DON) and the Minimum Data Set (MDS) nurse regarding resident 13 revealed: *She had been discharged from the facility on 10/29/15. *They had not documented a recap of her stay. *They did not have a Recap of Stay policy. *The DON considered the recap of stay a procedure.</p>	F 283	<p>F 283</p> <p>Correct to the individual: Resident 13's discharge summary was completed and put in closed record.</p> <p>Correct to all others: Discharge summary education was given to charge nurses and MDS coordinator on 4/21/16.</p> <p>System correction: Discharge summary is now in front of all charts and is part of the admission packet for all new admissions. Audits will be done monthly times 6 months by DNS or designee. <i>*Of the discharge summary of discharged residents.</i> Monitoring of System: <i>JT/SDOOTH/EL</i> The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.</p>	<i>5/26/16</i>	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364	<p>F 364</p> <p>Correct to the individual:</p>		

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 364	<p>Continued From page 6</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure nutritive value of food was maintained for one of two observed meal services by the addition of tap water to the vegetable for ten of ten residents (2, 7, 9, 14, 15, 16, 17, 18, 19, and 20) who were on pureed (smooth consistency) diets. Findings include:</p> <p>1. Observation on 4/4/16 at 5:05 p.m. in the kitchen of the food in the steam table revealed: *Pureed lima beans had been prepared and placed in a pan. *The above lima beans appeared watery. *They were not of a pudding thick consistency.</p> <p>Interview at the above time and location with cook A revealed she had: *Prepared the pureed lima beans for residents 2, 7, 9, 14, 15, 16, 17, 18, 19, and 20 by the following method: *Placed ten servings of the vegetables into a blender. *Added tap water from the one compartment sink into the blender with the vegetables. *Turned on the blender and pureed the vegetables and tap water together.</p> <p>Interview on 4/6/16 at 4:05 p.m. with the dietary</p>	F 364	<p>Meal was pulled and was redone to comply with the correct procedure for pureed food</p> <p>for resident 2, 7, 9, 14, 15, 16, 17, 18, 19, 20.</p> <p>Correct to all others: Education was given to all dietary staff on the policy and procedure of preparing pureed foods. Education was completed on 4/26/16 by the Dietary Manager.</p> <p>System correction: All cooks use the correct liquid to comply with the policy and procedure of making pureed foods. Audits will be completed weekly times 4 weeks and then monthly times four months. Audits will be completed by the Dietary Manager or Designee. <i>*for random meals at three meals per week for the first four weeks and then randomly for 4 months.</i> Monitoring of System: <i>JTISDCH/E</i> The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The Dietary Manager or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.</p>	<i>*5/26/16 JTISDCH/E</i>

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 364	Continued From page 7 manger revealed: *The above ten residents were on pureed diets. *She would have expected the cook to have used a liquid with nutritive value such as the vegetable juice or broth to make the required pureed consistency. *She confirmed the water added no nutritional value to the vegetable portions served to those residents on a pureed diet. Review of the provider's revised 3/7/08 unlabeled policy with directions for preparing pureed foods revealed: *Pureed foods should have been prepared in a consistent manner to have ensured nutritional content. *Vegetables were to have been prepared by the following: -Drain vegetable. -Measure (number of servings). -Use the drained liquid in the amount indicated. Review of the provider's revised 7/9/10 Pureed Foods policy revealed: *All pureed foods were to have been made with a compatible liquid to a consistency of pudding. *Liquids such as milk, hot gravy, or vegetable juice should have been used to add to the food item to have obtained the acceptable consistency. *Hot compatible liquids were to have been added to hot food. *"Tap water is never used in this facility for adding to pureed foods."	F 364		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency	F 425	F 425 Correct to the individual: System change will correct the cited deficiency.	5/26/16

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	<p>Continued From page 8</p> <p>drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to ensure used Fentanyl patches (a narcotic pain medication) were disposed in a secure manner for three of three staff (B, C, and D) in one of one observed janitor's closet. Findings include:</p> <p>1. Observation of the janitor's closet on 4/5/16 at 2:10 p.m. revealed: *The door had a sign stating where the key was located. *The key was found hanging at the nurses' station desk. *Sharps containers were in a box lined with a biohazard (potentially harmful to humans) bag.</p>	F 425	<p><i>*by the DNS JT/SDOHH/EL</i></p> <p>Correct to all others: All charge nurses will be educated on the new drug buster disposal system, new destruction of controlled medication policy and new locked box for the sharps container. Education was done 4/21/16. <i>*that included staff B, C, and D.</i></p> <p>System correction: <i>JT/SDOHH/EL</i> Drug buster disposal system is in place. New locked box for sharps container is in place, key to locked box is limited to charge nurse, DNS and Administrator. Audits will be done weekly times four weeks and then monthly times 4 months. Audits will be completed by DNS or designee. <i>*weekly on all Sharp containers and residents fentanyl patches.</i></p> <p>Monitoring of System: <i>JT/SDOHH/EL</i> The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.</p>	

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	<p>Continued From page 9</p> <p>*Other items were stored in the janitor's closet including chemicals and floor mopping supplies.</p> <p>Interview on 4/5/16 at 3:05 p.m. with registered nurse (RN) B revealed: *She discarded used Fentanyl patches in the sharps container (a container attached to the medication cart). *The sharps containers were placed in a box in the janitor's closet that was located by the nurses' station by the front door. *That door was to be locked. *The key for the door was kept hanging at the nurses' station desk.</p> <p>Interview on 4/5/16 at 3:15 p.m. with the director of nursing (DON) revealed: *She would have expected the used Fentanyl patches to be flushed down the toilet. *Full sharps containers were to have been placed in the janitor's closet. *The key to the janitor's closet was located at the nurses' station desk. *Everyone had access to that key. *They did not have a specific Fentanyl patch destruction policy. *They had been instructed to flush used Fentanyl patches by the pharmacy consultant.</p> <p>Interview on 4/6/16 at 6:00 p.m. with licensed practical nurse (LPN) D revealed she had been: *Discarding used Fentanyl patches in the sharps containers. *Placing full sharps containers in the janitor's closet. *Instructed on 4/6/16 to flush them from now on.</p> <p>Interview on 4/6/16 at 6:05 p.m. with RN C revealed she would have:</p>	F 425		

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 425	Continued From page 10 *Discarded used Fentanyl patches in the sharps container with two nurses present. *Placed full sharps containers in the janitor's closet. Review of the provider's 12/13/15 Controlled Substance Storage policy revealed: **"Only authorized licensed nursing and pharmacy personnel have access to controlled substances." **"The medication nurse on duty maintains possession of the key to controlled substance storage areas." Review of the provider's undated Controlled Substance Disposal policy revealed "Only authorized licensed nursing and pharmacy personnel have access to controlled medications."	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	F 441 Correct to the individual: System change will correct the cited deficiency. Correct to all others: All laundry staff was educated on the correct procedure to ensure laundry is sanitized per regulation on 4/26/16 by the Maintenance Supervisor. System Correction: →* that is a sanitizer A chemical additive has been added to the JT/SD000H/EL laundry machine in order to wash at lower temperature. Audits will be completed monthly times four. Audits will be	5/26/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	<p>Continued From page 11</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) 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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, record review, and interview, the provider failed to use a hot water or chemical sanitizer in one of two washing machines in the laundry room. Findings include:</p> <p>1. Observation and interview on 4/6/16 at 8:15 a.m. with laundry worker E revealed she thought they used hot water in the large washing machine to disinfect and sanitize the clothes. She manually added bleach to the smaller washing machine to disinfect and sanitize the laundry. The large washing machine was used daily for all types of laundry including residents' laundry. She was unsure how to get the water temperature to show on the large washing machine.</p>	F 441	<p>completed by Maintenance Supervisor or designee. *Of the chemical additive and water temperature of four randomly observed laundry loads per month. JTS/DOCH/EL Monitoring of System.</p> <p>The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The Maintenance Supervisor or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.</p>		

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 441	Continued From page 12 Interview and record review on 4/6/16 at 2:35 p.m. with the laundry supervisor revealed they used hot water disinfection/sanitizer. Their supplier took water temperatures for the large washing machine one time per month. The water temperatures of the washing machine were not taken on any other days of the month. Review of the supplier's water temperatures revealed the past three months the water temperatures were 102 degrees Fahrenheit (F), 103 degrees F, and 104 degrees F. Those temperatures were not hot enough to meet the hot water disinfection requirement of 160 degrees F for twenty-five minutes. The laundry supervisor then stated they used chemical disinfection, and one of the products they used included bleach. He was unable at that time to produce the product information. He stated he would request it from the supplier. Interview on 4/6/16 with the laundry supervisor at 4:55 p.m. and again at 8:00 p.m. prior to the survey team exiting the facility revealed they had not received the necessary information from the supplier to confirm they used a chemical sanitization process. They stated they were to receive an e-mail with the information the next morning on 4/7/16. Review of an e-mail from the administrator received on 4/7/16 at 3:58 p.m. stated the supplier was unable to provide the documentation needed to confirm the use of a chemical sanitizer.	F 441			
F 468 SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	F 468 Correct to the individual: The system change will correct the cited deficiency.	5/26/16	

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 468	Continued From page 13 This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation and interview, the provider failed to have handrails securely attached to the wall in one of three units (traumatic brain injury [TBI] unit). Findings include: 1. Observation on 4/5/16 at 3:09 p.m. in the TBI unit revealed: *The handrail at the top of the ramp at the entrance door on the left side had pulled away from the wall a half inch. *The handrails on both sides of the clean linen room had pulled away from the wall a quarter of an inch. *The handrails on both sides of the fire extinguishers had pulled away from the wall a quarter of an inch. *The handrails were loose outside residents' rooms 2 and 8. Observation and interview on 4/6/16 from 2:35 p.m. through 3:15 p.m. with the maintenance supervisor revealed: *He agreed the above handrails were loose and not securely attached to the walls. *There was not a preventative maintenance program for checking the handrails. *They did not have a policy and procedure for checking the handrails.	F 468	Correct to all others: All handrails are part of the maintenance checklist to be completed by the maintenance supervisor System correction: Handrail inspection was added to maintenance checklist to be completed during his rounds. Audits of the handrails in all three sections (TBI, CBU, and Manor) will be completed monthly for four months by the maintenance supervisor or designee. Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The Maintenance Supervisor or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514	Correct to the individual: Resident 7 now has a fluid flow sheet in place for staff to document all fluids and snacks. *for monitoring of fluid intake. JT/SDDOtt/EL	5/26/16

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/06/2016	
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 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 514	<p>Continued From page 14</p> <p>resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on record review and interview, the provider failed to document all fluid intake for one of two sampled residents (7) who was on a fluid restriction. Findings include:</p> <p>1. Review of resident 7's medical record revealed she was on a 1800 milliliters (ml) fluid restriction.</p> <p>Review of resident 7's 3/1/16 through 3/31/16 meal intake sheets revealed nine of ninety-three entries had not been completed. Those sheets had not included fluids provided at snack time.</p> <p>Interview on 4/6/16 at 3:30 p.m. with the dietary manager, licensed practical nurse D, and certified nursing assistant (CNA) F revealed: *CNA F had given resident 7 drinks for snacks when she worked. *There was no place to document fluids provided with snacks or medications. *They had not documented all fluid intakes at meals like they should have. *There was no other documentation to confirm</p>	F 514	<p>Correct to all others: Education was given to all nursing staff to ensure fluid flow sheets are being followed. Resident rights and dignity were also discussed in the education which was done on 4/21/16.</p> <p>System correction: Fluid flow sheets are in place to monitor residents that are on fluid restrictions. Audits will be done weekly times four and then monthly times four. Audits will be completed the DNS or designee. <i>*of the documentation of all residents on</i> Monitoring of System: fluid restrictions. The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to QAPI team for review and appropriate recommendations.</p>	JT/SPDOWEL

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/06/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH		STREET ADDRESS, CITY, STATE, ZIP CODE 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 514	Continued From page 15 they had maintained the 1800 ml fluid restriction for resident 7.	F 514		

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

ORIGINAL

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/07/16. Sunset Manor Avera Health (1966 original and 1997 addition building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 4/11/16 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 032 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and record review, the provider failed to maintain two conforming exits on each floor or fire section of the building. The east basement mechanical room had only one	K 032		F 3/24/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Adrian Staber

4-27-16

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.

MAY 02 2016

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

PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 032	Continued From page 1 conforming exit. Findings include: 1. Observation at 2:15 p.m. on 4/07/16 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 indicated that condition had existed since the original construction. The deficiency would not affect any resident smoke compartments. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiency identified in K000.	K 032		F

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

ORIGINAL

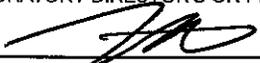
PRINTED: 04/18/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435100	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code(LSC) (2000 new health care occupancy) was conducted on 4/07/16. Sunset Manor Avera Health (2008 remodel building 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for new health care occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
-------	--	-------	--	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X8) DATE <i>4-27-16</i>
---	-------------------------------	-----------------------------

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.

MAY 02 2016
SD DOH L&C

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435100	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 4/7/2016
--	---------------------------------	---	---

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
---------------------	-----------------------------------

K 069	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was tied into the buildings fire alarm signaling system for one of one kitchen hood. Findings include:</p> <p>1. Document review at 3:30 p.m. on 4/07/16 revealed a commercial kitchen equipment inspection report dated 10/6/15. That report was prepared by Heiman Fire Equipment, Inc. The report revealed the commercial kitchen hood fire suppression system was not connected to the building fire alarm signaling system.</p> <p>Interview with the maintenance supervisor at the time of the above observation confirmed that condition.</p> <p>This deficiency has the potential to affect two of four smoke compartments.</p>
--------------	---

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

The above isolated deficiencies pose no actual harm to the residents

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/07/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 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 Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 4/04/16 through 4/07/16. Sunset Manor Avera Health was found not in compliance with the following requirements: S173 and S236.	S 000	*Addendums noted with an asterisk per 5/19/16 per telephone with facility DON. S173 JT/SDDOHEL Correct to the individual: System change will correct the cited deficiency.	
S 173	44:73:02:18(8-10) Occupant Protection The facility shall take at least the following precautions: (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp; (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and (10) The storage and transfilling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain shatterproof lamps in overhead lighting in two of two tub rooms (wing 1 and wing 3). Findings include: 1. Observation beginning at 1:15 p.m. on 4/07/16	S 173	Correct to all others: Shatter proof light bulbs will be installed in both tub rooms. System Correction: Installation of shatter proof bulbs will be installed in the tub room heat lamps. Audits will be completed monthly times 4 months and be completed by the Maintenance Supervisor or designee. Monitoring System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The Maintenance Supervisor or designee will be responsible for reporting all audits to QAPI team for review.	5/26/16

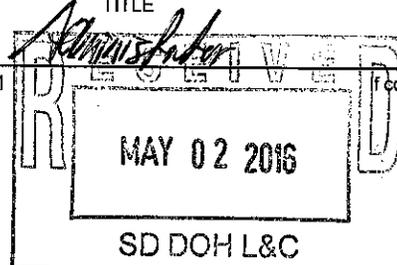
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

5J8Z11

TITLE



(X6) DATE

4-27-16

If continuation sheet 1 of 4

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 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 173	Continued From page 1 revealed dual heat lamps in the tub rooms in both wing 1 and wing 3. The heat lamps were not covered and were not provided with a shatterproof coating. Interview with the environmental services supervisor at the time of the observations confirmed those conditions.	S 173	S 236 Correct to the individual: Resident 11 had a chest xray and TB screening on 4/20/16.	
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not	S 236	Correct to all others: Education was given to charge nurse staff on TB policy, positive PPD reactors and the TB control binder. System Correction: Positive PPD reactors have been placed in the TB control binder to be completed by staff educator yearly. Audits will be completed monthly times 6. Audits will be completed by DNS or designee. Monitoring System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to QAPI team for review.	5/24/16

**All PPD reactors will be identified up on as needed. JT/SDDO/HEL*

**On all new admissions. JT/SDDO/HEL*

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 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 236	<p>Continued From page 2</p> <p>met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure one of one sampled resident (11) who was a positive tuberculin (TB) reactor (person who shows an adverse reaction) had received a medical evaluation and chest x-ray upon admission and had been evaluated annually with a record maintained of the presence or absence of signs or symptoms of TB. Findings include:</p> <p>1. Review of resident 11's medical record revealed he had: *An admission date of 6/9/14. *Diagnoses had included a history of positive reactor to TB testing. *Not received a chest x-ray since 4/22/14. *Not been evaluated annually for signs or symptoms of TB.</p> <p>Interview on 4/6/16 at 5:45 p.m. with the Minimum Data Set (MDS) coordinator regarding resident 11 revealed: *He was a positive TB reactor. *There had not been a chest x-ray and medical evaluation completed. *He had not been evaluated annually for signs and symptoms of TB. *The provider should have done a medical evaluation and chest x-ray upon admission. *The provider should have evaluated him annually with a record maintained of the signs or symptoms of TB. *Nursing was responsible for ensuring the above had been completed upon admission and annually.</p> <p>Review of the provider's revised March 2016 TB Testing Initial and Annual for LTC (long term care)</p>	S 236		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/07/2016
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUNSET MANOR AVERA HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 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 236	Continued From page 3 Residents policy revealed "A new resident who provides documentation of a positive reaction to the Mantoux skin test will have a medical evaluation and chest x-ray to determine the presence or absence of active TB disease."	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 32331 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 4/4/16 through 4/7/16. Sunset Manor Avera Health was found in compliance.	S 000		