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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING _____ B. WING _____	07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/10/23 through 7/13/23. Sunset Manor Avera Health was found not in compliance with the following requirement: F638.	F 000		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review, policy review, and interview the provider failed to ensure Minimum Data Set (MDS) assessments were completed in a timely manner for five of twenty-four sampled residents (3, 7, 19, 23, and 37). Findings include: 1. Review of the (MDS) schedule for the facility provided by MDS coordinator C on 7/12/23 revealed quarterly assessments for residents 3, 7, 19, 23, and 37 were to have been completed on 6/12/23. Review of the MDS transmission results summary report provided by MDS coordinator C on 7/12/2023 revealed no quarterly assessments had been submitted in June or July for residents 3, 7, 19, 23, and 37. Review of the providers 3/2022 LTC-Assessment (MDS Policy) revealed assessments would be "...completed within 14 days of the resident's	F 638	F638 Correct to the individual: MDSs for residents #3, #19, #23 & # 37 were completed and transmitted on 7/13/23, MDS for resident #7 was completed and transmitted on 7/14/23. System correction: 1)Admin/DON & MDS coordinator to review census report on a weekly basis to ensure MDSs are being completed in a timely matter. 2)Training for back-up MDS staff will be initiated by 08/25/23. 3)As of 08/5/23 all resident MDSs will be caught up and current. 4)MDS coordinator will plan to maintain timely completion and transmission of MDSs going forward. MDS coordinator will ask for assistance if needed to maintain timely completion and transmission of all MDSs. 5)Once trained, back-up MDS staff will assist with MDSs when MDS coordinator is out of the facility or if asked to assist due to heavy MDS load in order to keep MDSs completed and transmitted on a timely basis. Monitoring of system: Admin and/or DON or designee will audit MDS completion 1x/weekly for 4 weeks, then 2 times per month for 2 months and then 1x/monthly for 3 months and will review all audit findings with MDS coordinator. All results of audits will be reported & reviewed at monthly QAPI team meetings by DON or designee.	08/25/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin E. Stockland | TITLE: Administrator | (X6) DATE: 07/28/2023

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.

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 _____	07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 638	Continued From page 1 admission, quarterly, annually, and within any significant change in condition". Interview on 7/12/23 at 9:47 a.m. with MDS coordinator C regarding quarterly assessments for residents 3, 7, 19, 23, and 37 revealed: *Completed MDS assessments were transmitted via Internet Quality Improvement and Evaluation System at least weekly. *Her normal practice for transmitting MDS assessments was to do them in batches as she completes them. *She has been the MDS coordinator for ten years. *She was behind on completing quarterly assessments. *Her goal was to have them "completed by the end of the week". Interview on 7/12/23 at 3:14 p.m. with Administrator A regarding MDS quarterly assessments for residents 3, 7, 19, 23 and 37 revealed: *The expectation was to complete the MDS assessments by the due date. *When asked if she was aware that MDS assessments were overdue she sated "yes". *She stated no one else in the facility was trained on completing MDS assessments. *She stated a new registered nurse was hired the end of May, was completing facility orientation, and would be trained on MDS assessments and would assist as needed for timely submission.	F 638		

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 _____	07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 7/10/23 through 7/13/23. Sunset Manor Avera Health was found in compliance.	E 000		

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

TITLE: Administrator

(X6) DATE: 07/24/2023

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/11/23. Sunset Manor Avera Health (building 01) was found not in compliance 42 CFR 485.623 (d) (1) requirements for Critical Access Hospitals. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 7/11/23. Please mark an F in the completion date column for K241 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K226, K293, and K355 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=D	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview the	K 226	K226 System correction: Maintenance Director was able to repair the door on 7/11/23. Monitoring of system: Maintenance Director or designee will conduct audits on the doors 1x/weekly for 4 weeks and then monthly for 6 months with results being reported and reviewed at the monthly QAPI team meetings by Maintenance Director or designee. These types of doors will remain on the Maintenance Director's monthly checks even after the 6 months as before.	07/11/2023

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

TITLE
Administrator

(X6) DATE
07/28/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 226	Continued From page 1 provider failed to maintain the fire-resistive design of one randomly observed horizontal exit and building separation walls (between building 01 and building 02 outside the administrator's office). Findings include: 1. Observation and testing on 7/11/23 at 11:14 a.m. revealed the two-hour, fire-rated separation wall between building 01 and building 02 outside the administrator's office had A ninety-minute, fire-rated door that did not latch. That door did not close completely. When tested the door would strike the frame causing it to fail to completely close and latch. Interview with the maintenance director at that same time confirmed that condition. He stated he recently slowed down the closing of that door. He then went on to say he had been receiving complaints of that door slamming shut. He further added the humidity in the building seemed to affect the closing of that door. The deficiency could affect 100% of the occupants of both smoke compartments.	K 226		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced	K 241		F

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	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 241	Continued From page 2 by: Based on observation and record review, the provider failed to maintain two conforming exits on each fire section of the building. One of two areas (east basement mechanical room) had only one conforming exit. Findings include: 1. Observation on 7/11/23 at 1:36 p.m. revealed the exit stairway from the basement mechanical room discharged into the corridor system on the main level. The second exit from the basement mechanical room was through a window to an area well equipped with a fixed ladder. Review of the previous survey data indicated that condition had existed since the original construction. The deficiency would not affect any residents. The building meets the FSES. Please mark an F in the completion date column to indicate correction of the deficiency identified in K000	K 241		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain exit lighting for 3 randomly observed exit signs (wing three by T.V. lounge,	K 293	K 293 System correction: Maintenance Director contacted our local electrician on 7/11/23 to replace the 3 exit signs in question. 7/12/23: Nelsen Electric installed 3 new LED exit signs to replace the old ones noted to have burned out bulbs. Monitoring of system: Maintenance Director or designee will conduct audits of all exit signs 1x/weekly x 4 weeks and then 1x/monthly for 6 months with all results reported and reviewed at monthly QAPI meetings by Maintenance Director or designee. These will remain on the Maintenance Director's monthly checks even after the 6 months as before.	07/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 wing three north end and over the smoke doors on the south end in wing three). Findings include: 1. Observation on 07/11/23 at 11:45 p.m. revealed the exit sign in wing three by T.V. lounge was not functioning. That exit sign had both bulbs burnt out. Interview with the maintenance director at the time of the observations confirmed those conditions. The deficiency affected one location required to be provided with a marked and identifiable path of egress. 2. Observation on 07/11/23 at 11:46 p.m. revealed the exit sign over the exit door on the north end of wing three lounge was not functioning. That exit sign had both bulbs burnt out. Interview with the maintenance director at the time of the observations confirmed those conditions. The deficiency affected one location required to be provided with a marked and identifiable path of egress. 3. Observation on 07/11/23 at 11:44 p.m. revealed the exit sign over the smoke control doors on the south end of wing three lounge was not functioning. That exit sign had both bulbs burnt out. Interview with the maintenance director at the time of the observations confirmed those conditions. The deficiency affected one location required to be provided with a marked and identifiable path of egress.	K 293		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101	K 355	K355 System correction: 1) Maintenance Director checked all fire extinguishers on 7/27/23. 2) All fire extinguishers have been numbered & indicated on facility floor plan as of 7/28/23.	07/28/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/11/2023**

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

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K 355	Continued From page 4 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to properly maintain three randomly observed fire extinguishers (west basement stairwell, west basement, and central basement). Findings include: 1. Observation on 7/11/23 at 1:01 p.m. revealed the fire extinguisher at the top of the stairwell for the west basement had not received monthly checks since the contract maintenance was performed in March of 2023. 2. Observation on 7/11/23 at 1:04 p.m. revealed the fire extinguisher in the west basement had not received monthly checks since the contract maintenance was performed in March of 2023. 3. Observation on 7/11/23 at 1:40 p.m. revealed the fire extinguisher in the central basement had not received monthly checks since the contract maintenance was performed in March of 2023. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency has the potential to affect the entire facility.	K 355	(K 355 system correction continued) 3) An excel spreadsheet with fire extinguishers listed by number with attached facility floor plan has been completed as of 7/28/23 so monthly checks are easier to complete and monitor. Monitoring of system: Maintenance Director or designee will audit fire extinguishers being checked/inspected 1x/weekly x 4 weeks and then 1x/monthly for 6 months and findings will be reported and reviewed at monthly QAPI meetings. Fire extinguisher inspections will remain on the monthly maintence director check list as before.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **02 - BUILDING 02** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/11/23. Sunset Manor Avera Health (building 02) was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222	K 222 System correction: 1) Maintenance Director changed the code to the 2 doors on the unit on 7/11/23 and the staff in building 2 were educated on the code and the process of opening the doors in cae of an emergency. 2) Other Nursing and CNAs were educated on 7/18/23 during staff meetings. 3) All other staff have been educated/notified of the code and process by 7/28/23. 4) There is a panic button that has been in place since the locking system was installed on the unit in building 2. The panic button is located under the dining room clock. All staff have been educated on the location and the process as of 7/28/23. 5) Door process will be included in orientation for new employees going forward. Monitoring of system: DON or designee will complete audits of staff to be sure they know the code, where the panic button is and the process 1x/weekly x 4 weeks and then 2x/monthly x 2 months and then 1x/monthly x 3 months. Audits will be reported at the monthly QAPI Team meeting. The door alarms then be included on the Maintenance Director's monthly checks.	07/28/2023

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

TITLE: Administrator

(X6) DATE: 07/28/2023

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.

RECEIVED
JUL 28 2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **02 - BUILDING 02** B. WING	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **02 - BUILDING 02** B. WING _____	**07/11/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 222	Continued From page 2 failed to ensure staff can readily unlock egress doors at all times as required at two of three exit door locations (south exit door and East exit door). Findings include: 1. Observation on 7/11/23 at 2:11 p.m. revealed the traumatic brain injury unit south exit door was magnetically locked and could not be opened without knowledge of a special code. Interview at that same time with both the maintenance director and an unidentified certified nurse assistant revealed neither of them knew the code when asked. 2. Observation on 7/11/23 at 2:21 p.m. revealed the traumatic brain injury unit east exit door was magnetically locked and could not be opened without knowledge of a special code. Interview at that same time with both the maintenance director and an unidentified certified nurse assistant revealed neither of them knew the code when asked. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.5.2, TIA 12-4 (1)	K 222		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10636	A. BUILDING: _____ B. WING _____	07/13/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/10/23 through 7/13/23. Sunset Manor Avera Health was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/10/23 through 7/13/23. Sunset Manor Avera Health was found in compliance.	S 000		

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

TITLE: Administrator

(X6) DATE: 07/24/2023