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 _____	01/13/2022

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 Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/11/22 through 1/13/22. Sunset Manor Avera Health was found not in compliance with the following requirements: F656 and F880.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656	F656 Correct to the individual: Care plan for resident 30 was updated on 1/27/22 by the DON & Social Worker (SW) to include the diagnosis of aspiration via swallow study which changed the resident's diet to pureed with nectar thick liquids. Specific monitoring of resident by Nurse for signs or symptoms of aspiration, or recurring pneumonia along with specific monitoring due to frequent antibiotic use was also added to make it a more person-centered care plan. Care plan for resident 40 was also updated on 1/27/22 by DON & SW to include diagnosis of recurring urinary tract infections and monitoring resident for signs and symptoms of urinary tract infections along with specific monitoring due to frequent antibiotic use. Education was also provided to the resident concerning his supra-pubic catheter cares and this was also included on the care plan. System correction: Education was completed on 1/27/22 with care plan team and nursing staff regarding updating the working care plans with readmissions, new orders andnew prescriptions. Monitoring of system: Nurses will use double check system to monitor the updating of working care plans. The DON, IC nurse and MDS coordinator will meet monthly to review any high risk residents' care plans. Audits will be completed by DON or designee 1 time weekly for 4 weeks, then 2 times monthly for 2 months and then 1 time monthly for 3 months. All results of audits will be reported and reviewed at monthly QAPI meetings by DON or designee. F656 Addendum System correction: DON met with charge nurses 1:1 and completed educational session regarding transcribing all new orders, and all changes relevant to add to residents' working care plans. Second check process also reviewed with nurses for continued monitoring of working care plans to include individualized care plans for all residents. All education will be completed by 2/9/22 & this education will be included in new hire orientation. (cont.on next page)	02/09/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin R. Stockland	Administrator	02/04/2022

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
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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 656	Continued From page 1 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on record review, interview, and policy review, the provider failed to ensure a comprehensive care plan for two of nineteen sampled residents (30 and 40) with frequent urinary tract infections from an indwelling catheter and recurrent pneumonia. Findings include: 1. Record review of resident 30 electronic medical record revealed: *She had been discharged from the hospital on 11/4/21 with diagnosis of pneumonia. *An order for oral doxycycline 100 mg daily for 10 days. *Received nebulizer treatments three times per day. *On 12/5/21 she developed nausea, vomiting, and difficulty breathing. *She received nebulizer treatments three times per day. *She received IV fluids and antinausea medication from the provider 12/6/21. *She was re-hospitalized on 12/9/21 through 12/13/21 for recurrent pneumonia.	F 656	F656 Addendum Continued: Monitoring of system: We will audit 3 random care plans 1 time weekly for 4 weeks, then 2 times monthly for 2 months and then 1 time monthly for 3 months in order to maintain personalized, updated care plans for all residents at Sunset Manor and to ensure that all new orders or diagnoses are included on the care plans. Nurses will have ongoing education to reinforce second checks and care plan monitoring.	

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	435100	A. BUILDING _____ B. WING _____	01/13/2022

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

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F 656	Continued From page 2 *Had received an order for oral cefidinir 300 mg twice a day for 5 days related to pneumonia upon discharge from the hospital back to the provider. *She had continued to receive nebulizers three times per day. The care plan with an onset date of 7/18/17 had not mentioned any respiratory infection or treatment for respiratory conditions such as pneumonia. Interview on 1/13/22 at 9:15 a.m. with director of nursing (DON) B regarding resident 30's care plan revealed: *Agreed her care plan did not state anything about having pneumonia, or treatment related to it. *The resident had completed a swallow study during her last hospitalization and was diagnosed with aspiration. *She agreed that being at risk for aspiration was not documented on the care plan. *Her diet was changed to pureed with nectar thick fluids after the diagnosis of aspiration. 2. Record review of resident 40's electronic medical record revealed: *He was admitted on 8/19/21 with a suprapubic catheter (a tube inserted into the bladder through a small hole in the stomach that drains urine into the external bag). *While he used a leg bag during the day, he used a regular catheter bag at night. *He needed assistance at times with changing bags. *He preferred to perform own catheter cares. *His suprapubic catheter was changed every 4 weeks. *He had been diagnosed with a urinary tract	F 656		

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F 656	Continued From page 3 infection (UTI) on 9/29/21 and again on 11/11/21. *Care plan had not indicated resident was at risk for frequent UTI's nor interventions to help prevent infection. Interview on 1/12/22 1:21 p.m. with DON B regarding resident 40's care plan revealed: *Resident 40 wanted to be independent with catheter care. *"Didn't like to hearing instructions from staff." *Agreed that the care plan had not indicated that the resident was at risk for frequent UTI's nor interventions used to treat recurrent infections. Policy review of providers baseline care plan revised on 3/19 revealed: *The baseline care plan will include conditions and risks affecting the resident's health and safety. Examples included: *infections.	F 656		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880	Directed Plan of Correction Sunset Manor Avera Health F880 Corrective Action: 1. For the identification of lack of: *Appropriate hand hygiene glove use by staff during resident personal cares. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 2/7/22 by IC/education nurse or DON. Identification of Others: 2. ALL residents and staff have the potential to be affected if lack of: *appropriate hand hygiene and glove use by staff during resident personal cares. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 2/7/22 by the IC/education nurse or DON to all care staff including agency staff. (F880 continued on next page)	02/07/2022

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F 880	Continued From page 4 reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the	F 880	F880 continued System Changes: 3. Root cause analysis conducted answered the 5 Whys: Issue: CNAs C & D did not change gloves when performing peri-care on a resident. Why - agency staff state they did not know they were supposed to change their gloves. Why - agency staff do not attend/participate in facility education sessions as they are supposed to get this education and training from their agency. Why - staffing agencies are supposed to provide all education to their staff prior to being assigned to our facility, but no ongoing staff education has been provided to the facility by the staffing agency. Why - facility contract with agency states that the agency is responsible for all training and on-going education of their staff. Why - no formal on-going education correspondence between facility and staffing agency had occurred. Administrator, DON, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Admin, DON & IC/education nurse contacted the South Dakota Quality Improvement Organization (QIN) on 2/2/22 and include a brief detail of discussion - we discussed the directed plan of correction for the recent SD DOH survey and the steps that we have taken and plan to take to assure our staff are educated in proper hand hygiene. We were provided with infection control resources by the QIN quality improvement advisor. Monitoring: 4. Admin, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring and demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Admin, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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	435100	A. BUILDING _____ B. WING _____	01/13/2022

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

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F 880	Continued From page 5 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on observation, interview, and policy review, the provider failed to ensure proper hand hygiene and glove use by one of one certified nursing assistant (CNA) while performing cares for one of nineteen sampled residents (15). Findings include: Observation on 1/12/22 at 8:14 a.m. of cares for resident 15 with CNA C and CNA D revealed: *Both staff were wearing gloves. *Resident was incontinent of urine. *CNA C performed peri care using disposable wipes. *CNA D helped with positioning resident. *With the same gloves performed the following: -Placed a clean brief on the resident. *Helped resident dress for the day. *Returned wipes to dresser drawer. *Removed gloves and washed hands. *Put clean gloves on then washed resident's face. *Removed gloves and exited the room with garbage bag. *No hand hygiene after removing gloves. Interview with CNA C following the observation revealed she:	F 880		

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

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

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F 880	Continued From page 6 *Had worked at the facility for 2 months. *Received hand hygiene training through staffing agency. *Had not realized she was supposed to change gloves after performing peri care. Interview on 1/12/22 at 1:11 p.m. with director of nursing B regarding the observation of the CNA's revealed: *Agreed hand hygiene had been missed. *Stated that agency staff should have had all of their training. *"She expected staff to perform hand hygiene appropriately." Review of the provider's undated nursing policy and procedure for male resident perineal care revealed: *After the perineal area was cleansed staff were to remove their gloves and perform hand hygiene.	F 880		

South Dakota Department of Health

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	10636	A. BUILDING: _____ B. WING _____	01/13/2022

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SUNSET MANOR AVERA HEALTH	129 E CLAY ST IRENE, SD 57037

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S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/11/22 through 1/13/22. Sunset Manor Avera Health was found in compliance.	S 000		01/26/22
S 000	Compliance/Noncompliance Statement Surveyor: 16385 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 1/11/22 through 1/13/22. Sunset Manor Avera Health was found in compliance.	S 000		01/26/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robin R. Stockland	Administrator	01/26/22

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
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E 000	Initial Comments Surveyor: 16385 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 1/11/22 through 1/13/22. Sunset Manor Avera Health was found in compliance.	E 000		01/26/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland
TITLE: Administrator
(X6) DATE: 01/26/22

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

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	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/12/2022**

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 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/12/22. Sunset Manor Avera Health (Building 1) 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 and the Fire Safety Evaluation System (FSES) dated 1/19/22. 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 K351, and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 241 SS=C	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by:	K 241		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin E. Stockland | TITLE: Administrator | (X6) DATE: 02/01/2022

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FEB 01 2022

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 _____	01/12/2022

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K 241	Continued From page 1 Surveyor: 40506 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 1/12/22 at 11:15 a.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 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and	K 351	K351 Building Sprinkler Inc was in the facility from 01/25/22 through 01/27/22 and completed the sprinkler system in the west boiler room.	01/27/22

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 _____	**01/12/2022**

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(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 351	Continued From page 2 sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to provide sprinkler protection throught the facility as required. The west boiler room was not covered by the automatic fire sprinkler system. Findings include: 1. Observation at 10:30 a.m. on 1/12/22 revealed the west boiler room was not sprinkled. The deficiency could affect 100% of the smoke compartment occupants. Interview with the maintenance manager at the time of the observation confirmed the observation. A recheck of the boiler room prior to exit confirmed the observation as well.	K 351		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test	K 353	K 353 Sprinkler System inspection is completed on an annual basis by Building Sprinkler Inc. A quarterly flow test is also completed by Building Sprinkler Inc. The last annual inspection was completed on 08/17/21 and the last quarterly flow test was on 11/10/21 with the next quarterly flow test scheduled for 02/03/22. The Maintenance Director was trained by a Building Sprinkler Inc technician on 01/27/22 on how to run the monthly churn/no flow tests for the fire pump. The test was then completed on 01/27/22 and a process of completing on a monthly basis has been established. An out of service water tank inspection has been scheduled for this spring. This will be completed as soon as the weather allows as the entire tank needs to be emptied. This inspection will be completed by Complete Restoration, LLC which was set up by Building Sprinkler Inc.	03/04/22

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 _____	**01/12/2022**

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 353	Continued From page 3 c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review and interview, the provider failed to continuously maintain the automatic fire sprinklers in reliable operating condition by doing fire pump churn/no flow tests on a monthly basis and by performing water storage tank inspection and maintenance during the last year. Findings include: 1. Based on record review on 1/12/22 at 1:00 p.m. the required monthly churn/no flow tests had not been performed in the past year. Quarterly flow tests in the past twelve months had been performed, hence the fire pump had functioned four times. Interview with maintenance manager at the time of the record review and during the facility tour confirmed that churn/no flow tests had been performed. There was mention of the required testing in the fire testing manual, but the maintenance manager was unaware of the requirement. Failure to continuously maintain the automatic fire sprinkler system as required increased the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic fire sprinkler system.	K 353		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/12/2022**

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SUNSET MANOR AVERA HEALTH	**129 E CLAY ST** **IRENE, SD 57037**

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K 353	Continued From page 4 Reference NFPA 25, 2011 edition, 8.3.1. 2. Based on record review on 1/12/22 at 1:00 p.m. the required inspection, testing and maintenance for the water storage tank has not been performed in the past year. Interview with maintenance manager at the time of the record review and during the facility tour confirmed that no tank inspection, testing or maintenance had been performed. Failure to continuously maintain the automatic fire sprinkler system as required increased the risk of death or injury due to fire. The deficiency affected numerous required tests on the automatic fire sprinkler system. Reference NFPA 25, 2011 edition, 9.1.1.2.	K 353		

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	435100	A. BUILDING **02 - BUILDING 02** B. WING _____	**01/12/2022**

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 Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/12/22. Sunset Manor Avera Health 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 deficiencies identified at K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353	K353 Sprinkler System inspection is completed on an annual basis by Building Sprinkler Inc. A quarterly flow test is also completed by Building Sprinkler Inc. The last annual inspection was completed on 08/17/21 and the last quarterly flow test was on 11/10/21 with next quarterly flow test scheduled for 02/03/22. The Maintenance Director was trained by a Building Sprinkler Inc technician on 01/27/2022 on how to run the monthly churn/no flow tests for the fire pump. The test was then completed on 01/27/2022 and a process of completing on a monthly basis has been established. An out of service water tank inspection has been scheduled for this spring. This will be completed as soon as the weather allows as the entire tank needs to be emptied. This inspection will be completed by Complete Restoration, LLC which was set up by Building Sprinkler Inc.	03/04/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin E. Stockland — TITLE: Administrator — (X6) DATE: 02/01/2022

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 **02 - BUILDING 02** B. WING _____	**01/12/2022**

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 353	Continued From page 1 by: Surveyor: 40506 Based on record review and interview, the provider failed to continuously maintain the automatic fire sprinklers in reliable operating condition by doing fire pump churn/no flow tests on a monthly basis and by performing water storage tank inspection and maintenance during the last year. Findings include: 1. Based on record review on 1/12/22 at 1:00 p.m. the required monthly churn/no flow tests had not been performed in the past year. Quarterly flow tests in the past twelve months had been performed, hence the fire pump had functioned four times. Interview with maintenance manager at the time of the record review and during the facility tour confirmed that churn/no flow tests had been performed. There was mention of the required testing in the fire testing manual, but the maintenance manager was unaware of the requirement. Failure to continuously maintain the automatic fire sprinkler system as required increased the risk of death or injury due to fire. The deficiency affected one of numerous required tests on the automatic fire sprinkler system. Reference NFPA 25, 2011 edition, 8.3.1. 2. Based on record review on 1/12/22 at 1:00 p.m. the required inspection, testing and maintenance for the water storage tank has not been performed in the past year.	K 353		

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	435100	A. BUILDING **02 - BUILDING 02** B. WING _____	**01/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 2 Interview with maintenance manager at the time of the record review and during the facility tour confirmed that no tank inspection, testing or maintenance had been performed. Failure to continuously maintain the automatic fire sprinkler system as required increased the risk of death or injury due to fire. The deficiency affected numerous required tests on the automatic fire sprinkler system. Reference NFPA 25, 2011 edition, 9.1.1.2.	K 353		