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	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Avera Health	129 E Clay St Irene, SD 57037

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43021 Based on a facility-reported incident (FRI) review, observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (37) who was cognitively impaired received adequate care and monitoring to ensure she was free of physical restraints imposed for discipline or convenience and not required to treat the resident's medical symptoms that resulted in an incident of resident abuse by one of one agency staff member (H). Findings include: 1. Review of the South Dakota Department of Health (SD DOH) event report for resident 37 on 6/28/24 revealed: *She returned from the hospital on 6/28/24 at 6:35 p.m., was restless, and had tried multiple times to stand up from her chair. -She was unsteady when walking. -She was redirected to sit in her wheelchair by agency certified nursing assistant (CNA) H. -For nearly an hour and half resident [resident 37] continues to try to stand up or get out of the wheelchair and resists against [first name of agency CNA H] but is physically restrained against and to the wheelchair by [first name of agency CNA H]. --During this time [first name of agency CNA H] is physically holding [resident 37's first name]'s arms down to the wheelchair, what appears to be digging her chin into [resident 37's first name]'s scalp, towers over resident and appears to have several verbal exchanges with resident. -At 8:51 p.m. nurse [agency registered nurse (RN) I] comes back to unit and rubs [resident 37's first name]'s back and talks with her which calms her down. -2nd nurse [LPN J] comes back to unit at 8:54 p.m. and also talked to [resident 37's first name] and they [agency RN I and LPN J] take her to recliner on unit and she does not want to sit there . -They [agency RN I and LPN J] then take her down to her room and she is calm. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Observation on 8/6/24 at 2:07 p.m. of resident 37 revealed she was in the activity room involved with a resident group activity led by a local pastor. She was sitting in a chair and actively singing a hymn with the pastor and other residents. 3. Interview on 8/6/24 at 4:00 p.m. with resident 37 in her room revealed: *She enjoyed pastor visits, watching movies, and loved to read. *She could not remember any staff member being upset with her, raising their voice to her, or holding her down, stating They [the staff] are very good to me. *She had no recollection of the 6/28/24 incident or having been to the hospital that day. 4. Review of Resident 37's electronic medical record (EMR) revealed: *She was admitted to the facility on [DATE]. *After her admission, she was moved to a room in the provider's challenging behavior unit (CBU). *She was sent to the [another community] hospital's emergency roiagnom on the afternoon of 6/28/24 after the resident was exhibiting slurred speech, left-sided weakness, and facial droop. -She had been given IV [intravenous] fluids and IV Ativan [medication given to relieve anxiety] for her CT [computed tomography] scan while at the hospital. -She returned from the hospital on 6/28/24 at 6:30 p.m. to her room in the CBU. *Her diagnoses included: -Unspecified dementia, with other behavioral disturbances. -Bipolar disorder. -Alzheimer's disease. -Paroxysmal atrial fibrillation. *Her 6/17/24 annual minimum data set (MDS) assessment revealed: -Her brief interview for mental status (BIMS) was scored at 12, which indicated she was moderately impaired cognitively. -She had exhibited no behavioral symptoms in the past week. -She was independent with dressing, eating, and walking with a walker. -She was independent with toileting but had some occasional urinary incontinence. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 37's EMR progress notes revealed: *On 6/28/24 a progress note was entered by director of nursing (DON) B at 2:56 p.m. which stated, CNA came to recorder [DON B]'s office around 1415 [2:15 p.m.] and reported that resident has had a significant decline this afternoon . was very lethargic, required 2 [staff members] extensive assist to get to bed. Staff assisted her to bed . she was leaning to the right, weak with garbled speech . This recorder [DON B] notified Dr [last name of physician] and went immediately to room to examine resident. Performed stroke screen, able to shrug shoulders, stick out tongue, squeeze fingers with grip weakness on the left, was not able to sit up unsupported with leaning to both sides, more-so to the left noted. Resident had very garbled speech . Dr [last name of physician] . requests her to be sent out via EMS [emergency medical services]. [First name of guardian] notified of condition and that resident will be sent out via ambulance. *On 6/28/24 a progress note was entered at 3:06 p.m. by LPN K updating the resident's guardian on her status. *On 6/28/24 a progress note was entered at 9:35 p.m. by RN I which stated Patient returned from ED [emergency department] at 1830 [6:30 p.m.]. Report received from discharging nurse. CT [computed tomography] scans negative. CBC [complete blood count], CMP [comprehensive metabolic panel], UA [urinalysis] all WNL [within normal limits]. Given IV [intravenous] fluids and IV [intravenous] Ativan [medication given to relieve anxiety]. No discharge diagnosis . Patient is agitated and looking for her nephew to pick her up. Combative with staff. Took HS medications with no problems, went to bed at 2130 [9:30 p.m.] . *There was no progress note related to the physical restraint of the resident by agency CNA H 5. Review on 8/6/24 of resident 37's current care plan revealed: *A focus area I have memory problems, have poor safety awareness, and make poor decisions. I have clear speech. I can usually express my needs. I can usually understand others. *A focus area I take psychotropic medications. I have physical outbursts. I have mood problems . -Interventions included: --I admitted to [name of provider's nursing unit] on 06-26-2023 from [the provider's trade name] behavioral health center in [another community], SD. I need 24 hour supervision . I was approved for challenging behavior [unit] . on 6/26/2023 . --I am followed by [provider's trade name] behavioral health for medication management. 6. Interview on 8/7/24 at 3:07 p.m. with DON B regarding the 6/28/24 incident revealed: *Agency CNA H had been scheduled to work at 3:00 p.m. on 7/3/24 but did not show up for her shift. *She reached out to CNA H by cell phone with no response. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Another unidentified agency CNA had informed her that agency CNA H had left her assignment at the nursing home for her home state of Louisiana due to her being left in the behavior unit by herself. *On 7/3/24 she emailed the agency that employed CNA H and asked regarding CNA H. *The reply she received informed her that CNA H was leaving her contract with the provider due to being alone in the behavioral unit for a couple of hours last Friday night, 6/28/24. *She was unaware of the 6/28/24 incident until Wednesday, 7/3/24. *On 7/3/24, after the emailed reply, she and administrator A reviewed the video footage from the CBU unit from Friday, 6/28/24. -Agency CNA H was seen physically in front of resident 37, who was seated in a wheelchair, holding the resident's forearms down on the wheelchair's armrests and agency CNA H's chin resting on the resident's forehead. *After reviewing the video footage, DON B asked the CBU unit coordinator about the 6/28/24 incident and agency CNA H. -CBU unit coordinator stated CNA H had worked Friday evening, 6/28/24 and then the following Sunday, Monday, and Tuesday. -Two CNAs that were scheduled on the CBU at 7:00 p.m. on 6/28/24. -The CBU unit coordinator had stated that no one had reported anything to her regarding the incident on 6/28/24. *DON B stated the CBU unit coordinator had resigned from her position with the provider two weeks ago and no longer worked at the facility. 7. Interview on 8/7/24 at 3:48 p.m. with administrator A and DON B regarding the 6/28/24 incident revealed: *Both agreed that the abuse of resident 37 had occurred with agency CNA H physically restraining the resident for a combined time of 20 minutes that occurred periodically throughout the ninety minutes she was attending to the resident on the CBU unit. -Other staff were seen coming in and out of the CBU unit during this time, but none of the staff had witnessed CNA H physically restraining the resident. --Agency RN I had passed medications on the CBU unit and another nursing unit. --CNA M and LPN J were also seen on the CBU unit that evening. --Agency CNA L had been scheduled to be on the CBU unit that evening, but was not seen on the video footage during that time as she may have been pulled to another nursing unit. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*DON B stated resident 37's assessment after the incident revealed no harm was evident, but based on the video footage, she verified the physical restraint of the resident had occurred. *Both agreed the video footage was limited to the hallway by the nursing station. 8. Review of the provider's January 2024 LTC (long term care) Abuse Prohibition policy revealed: *It is essential for facilities to prohibit and prevent abuse, neglect, exploitation of residents . including freedom from physical . restraints not required to treat a resident's medical symptoms. The facility will have systems in place to encourage and support all residents, staff, . in reporting any suspected acts of abuse . *Physical restraint is defined as any manual method, .that meets all of the following criteria: -i. Is attached or adjacent to the resident's body; -ii. Cannot be removed easily by the resident; and -iii. Restricts the resident's freedom of movement .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50015 Based on South Dakota Department of Health (SDDOH) complaint report review, record review, policy review and interview the provider failed to ensure 15 of 22 (2, 3, 7, 8, 14, 16, 20, 23, 25, 26, 29, 33, 35, 41, 43) Elopement risk evaluations were completed accurately to ensure resident safety. Findings include: 1. Review of SDDOH complaint report revealed: *Resident 43 had eloped from the building on 7/17/24 out a door that had an alarm. *The alarm did not sound and alert staff to a resident exiting the building. *Staff observed resident 43 walking with a walker across the front lawn of the building. *They assisted him back into the building. *Nurse completed vitals and assessed him to make sure he was okay. *Staff checked all other doors in the building, making sure all other alarms were working. 2. Review of resident 43's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had diagnoses of: -Macular degeneration. -Dementia with other behavioral disturbances. *Brief interview for mental status (BIMS) score is 9 meaning moderate impairment. *Elopement risk evaluations that were completed revealed: *On admitted d 4/10/23 he was not at risk for elopement with a score of three. *On 7/8/23 following an elopement he was not at risk for elopement with a score of 4. *Elopement risk evaluation scoring/summary of risk indicated Three or more Resident Status/Potential Risk Factors and/or one or more Definitive Risk Factors indicate a resident AT RISK for elopement. *No elopement risk evaluation was completed after 7/8/24 elopement. *The working care plan had a written elopement documented risk dated 7/18/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of residents (2, 3, 7, 8, 14,16, 20, 23, 25, 26, 29, 33, 41) elopement risk evaluations revealed: *They all scored three or more. *They were marked as not being at risk for elopement. 4. Review of provider's Elopement policy dated 8/2024 revealed: *It is the policy of Sunset Manor to investigate and report all cases of missing residents off facility grounds. *The elopement of a resident occurs when a resident has left the premises without the knowledge of a staff member. *Charge nurse will complete Incident report in Risk Management, complete detailed progress note, and complete an Elopement risk evaluation. 5. Interview on 8/7/24 at 2:40 p.m. with registered nurse (RN) F revealed: *Social service designee D would have updated the care plan for the resident in 7/2024. *A new elopement risk evaluation should have been completed by the nurse working on 7/17/24. *The stop sign on the door had been there for around six years. 6. Interview on 8/7/24 at 3:03 p.m. with minimum data set (MDS) coordinator C revealed: *The elopement should have been added to the working care plan signature sheet where changes were added, and updated. *The nurse working on 7/17/24 should have added it to the signature sheet. *Resident 43 is due for annual elopement risk evaluation in 3/2025. *She agreed resident 43 was marked wrong on the elopement risk evaluation as not being at risk for elopement. *He did not have a new elopement risk evaluation completed after he eloped on 7/17/24. 7. Interview on 8/7/24 at 3:20 p.m. and 8/8/24 at 8:16 a.m. with SS designee D revealed: *She added the elopement risk to resident 43's working care plan following his elopement on 7/17/24. *Licensed practical nurse (LPN) G should have added it after the event. -She had not though it was an elopement. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She had not though it was a reportable incident. *Resident 43 had eloped from the building once before. 8. Interview on 8/8/24 at 8:22 a.m. with director of nursing (DON) B revealed: *Elopement risk evaluations were completed on admission and if an elopement occurred. 9. Interview on 8/8/24 at 9:50 a.m. with administrator A and DON B revealed: *They agreed resident 43's elopement risk evaluation was marked incorrectly as not at risk. *They expected an elopement would have been addressed in the resident's care plan. *They confirmed there was nothing in resident 43's current care plan or the EMR about being at risk for elopement. *They agreed that anyone with a score of three or more on the elopement risk evaluation should have been marked as at risk for elopement. *They were in the process of changing from American Health Tech to Point Click Care for their EMR system.