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	09/25/2024

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 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 50015 Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, video review, and policy review, the provider failed to protect six of eight sampled residents (1, 2, 3, 5, 7, and 8) from neglect by licensed practical nurse (E) who did not offer or provide repositioning or toileting assistance as directed in their plans of care. Findings include: 1. Review of the 9/12/24 SD DOH complaint revealed: *The complainant wanted to remain anonymous. *There was concern regarding neglect for all residents in the Traumatic Brain Injury (TBI) unit. *From 9/7/24 at 10:00 p.m. to 9/8/24 at 6:00 a.m. -Resident 5 was left in the same clothes he was dressed in on 9/7/24. -He was curled up in a ball on the floor with no blanket. -He was cold to the touch. -He was covered in feces. -His bed was still made from the previous day. *Residents (1, 2, 3, 7, and 8) were identified as being incontinent of both bowel and bladder in the complaint. *Complainant requested a review of the video footage of the unit. 2. Review of resident 1's electronic medical record (EMR) revealed: *His diagnoses included: -Traumatic subdural hemorrhage with loss of consciousness. (blood pooling between the brain and the outer layer of the brain-protective membrane). (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	-Urinary incontinence. -Major depressive disorder. -Cognitive communication deficit. -Restlessness and agitation. -Impulse disorder. *His Brief Interview for Mental Status (BIMS) score was 4 which indicated he had severe cognitive impairment. *He required the assistance of one to two staff with all mobility, toileting, personal hygiene, and dressing. *He was to be checked (for incontinence needs) and changed every 2 hours. 3. Review of resident 2's EMR revealed: *His diagnoses included: -Traumatic subdural hemorrhage with loss of consciousness. -Fracture of base of skull. -Mental disorder due to known physiological condition. -Psychotic disorder. -Anxiety disorder. -Cerebral infarction due to thrombosis (stroke due to a blood clot). -Hemiplegia and hemiparesis (paralysis) following a cerebral vascular disease (conditions that affect blood flow to the brain). *His BIMS score was 99 which indicated he chose or could not participate. *He had incontinence and was to be checked and changed every 2 hours. *He was dependent on two staff to assist him with all activities of daily living (ADLs). *He was dependent on staff for assistance with all his toileting, hygiene, dressing and personal hygiene needs. *He required the use of a total body mechanical lift for all transfers. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	*He was known to hit staff. *He had a gastrostomy tube (G-tube) for nutrition and medication administration and is nothing by mouth. 4. Review of resident 3's EMR revealed: *His diagnoses included: -Vascular dementia. -Major depressive disorder. -Hemiplegia (paralysis) following nontraumatic intracerebral hemorrhage (bleeding in brain). -Psychosis (disconnection from reality). *His BIMS score was 7 indicated he had severe cognitive impairment. *He had incontinence and was to be checked and changed every 2 hours. *He requires one to two staff to assist him with his bed mobility, bathing, toileting, and personal hygiene needs. *He required the use of a sit-to-stand lift for transfers. 5. Review of resident 5's EMR revealed: *His diagnoses included : -Dementia with behavioral disturbances. -Nontraumatic intracranial hemorrhage (stroke that occurs from a blood pooling in brain). -Anoxic brain damage (lack of oxygen to the brain). -Sleep disorder. *His BIMS score is 99 and he had inattention that would fluctuate. *He had incontinence of his bowel and bladder. -He used incontinence products. -He needed the assistance of one staff with his toileting needs every 2 hours. 6. Review of resident 7's EMR revealed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	*His diagnoses included: -Traumatic subarachnoid hemorrhage with loss of consciousness. -Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. -Dementia, severe with behavioral disturbances. -Major depressive disorder, recurrent, severe with psychotic symptoms. *His BIMS score was 1 which indicated he had severe cognitive impairment. *He had incontinence of his bowel and bladder. -He required substantial/maximal staff assistance for his transfers and ADLs. -He required the use of a total mechanical lift at times with the assistance of two staff. *He had a history of physical outbursts, verbal aggression, resistance with care, and social and sexually inappropriateness. 7. Review of resident 8's EMR revealed: *Her diagnoses included: -Dementia without behavioral disturbances. -Nontraumatic intracerebral hemorrhage (stroke that occurs from a blood pooling in brain). -Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (paralysis following a stroke). -Neuromuscular dysfunction of the bladder (muscles in the bladder do not work properly) with stress incontinence. *BIMS score of 99, and indicated she was unable to participate. *She required substantial to maximal assistance of two staff with all of her ADLs and mobility. *She had incontinence of her bowel and bladder. -She required to be checked and changed every two hours, and staff were to assist her with her incontinent care needs at each episode. 8. Interview on 9/24/24 at 4:45 p.m. with certified nursing assistant (CNA) F revealed: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	*She had worked on the TBI unit 9/8/24 and at 6:00 a.m. that day: *Resident 1 was incontinent of both bowel and bladder and his bedding was soaked through. *Resident 2 was soaked in urine from head to toe and bedding was soaked through. *She found resident 5 lying on the floor, in the living room area of his room. -His body was curled up in a ball, and his skin was cold to the touch. -He had feces on him and was incontinent of urine. *She stated he should have been assisted with toileting every two hours and that he would at times lay on the floor, but would stay in bed if staff placed him in his bed. -He had on the same clothes she had dressed him in on the 9/7/24 morning shift. *Resident 6 was incontinent, and his bed was soaked with urine. *Resident 8 was incontinent of bladder and bedding was soaked through. *She stated all of those residents required staff assistance with their toileting needs every two hours. 9. Interview on 9/25/24 at 8:02 a.m. with licensed practical nurse (LPN) E revealed: *He had worked on 9/7/24 from 6:00 p.m. to 9/8/24 at 6:00 a.m. and was assigned to be the nurse in the TBI and CBU (challenging behaviors unit) from 6:00 p.m. to 10:00 p.m. that night. *He said he went to the TBI unit on 9/7/24 at 10:00 p.m. to work only on TBI unit till 9/8/24 at 6:00 a.m. *He was unsure why a CNA was not assigned to the TBI unit. *He completed toileting and personal cares for the TBI unit residents from 10:00 p.m. on 9/7/24 until 6:00 a.m. on 9/8/24. *He did not know which residents needed to get up in the morning. *He completed all point click care (PCC) EMR charting. *He stated resident 5 would lie on the floor at times. *He said typically, there were three CNAs and two nurses in the building from 10:00 pm to 6:00 a.m. *He had not been trained to perform the CNA tasks. 10. Interview on 9/25/24 at 9:20 a.m. with LPN D revealed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	*She was the nurse for the TBI and CBU on 9/8/24 at 6:00 a.m. *She had been told resident 5 had been up all night and had not slept from a report with LPN E. *Resident 2 had been spitting and kicking at LPN E and he needed assistance to change him. *CNA F had told her resident 2 was soaked. *She stated the CNAs working that morning never contacted her regarding complaints about residents' care. *On 9/8/24 at 6:30 a.m. she had washed up resident 2 and changed his bedding, because he had soaked through the incontinence soaker pad and all of his bedding. *She stated, resident 7 did not like male staff. 11. Interview on 9/25/24 at 9:50 a.m. with director of nursing (DON) B revealed: *Tasks are automated in the PCC EMR system with assessments when completed. *Tasks can be added independently. *Registered nurse (RN)/Minimum Data Set (MDS) H was in charge of reviewing tasks and updating them when needed. *Social worker (SW) C was in charge of updating resident care plans. 12. Interview on 9/25/24 at 10:42 a.m. with RN/MDS H revealed: *She did not enter the tasks for residents in PCC. *She thought DON B or medical records (MR) I entered the tasks. *She did not know who updated the resident pocket care plans for staff. 13. Interview on 9/25/24 at 10:50 a.m. with MR I revealed: *She did not enter tasks in PCC. *She did not update the pocket care plans. 14. Interview on 9/25/24 at 10:52 a.m. with DON B revealed: *Everyone in management had access to update the pocket care plans. *Pocket care plans were kept at the front desk for staff. *DON B would update the pocket care plans for the main floor residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	*MR I printed them off and placed them at the front desk for staff. 15. Interview on 9/25/24 at 12:05 p.m. with Administrator A and DON B revealed: *LPN E had training completed on 9/6/24 with LPN M. *All nurses would have received CNA training in nursing school. *The standard nursing care for incontinent residents was to check and change or toilet them every two hours. *They had checked with other facilities and they did not put toileting tasks in PCC for every two hours. *There had been no communication to management that there was a problem on the 9/7/24 and 9/8/24 weekend from the TBI nursing staff. *DON B had contacted LPN E employment agency in regards to him needing to improve on his required tasks while working in the facility before she had learned of the complaint. 16. Interview on 9/25/24 at 1:20 p.m. with DON B revealed: *She completed the schedule for nursing staff. *Usual staffing for a 10:00 p.m. to 6:00 a.m. shift included is two nurses and three CNAs in the building. *She stated one of the CNAs scheduled to work had called in on 9/7/24. *Her expectation for residents who needed two staff for assistance with their care needs was that staff would be assisted by staff from another unit. 17. Interview on 9/25/24 at 1:41 p.m. with CNA G revealed: *She worked 9/7/24 at 6:00 p.m. until 9/8/24 at 6:00 a.m. *Pocket care plans are available at the front desk where report was given. *She was on the CBU for her shift that day. *She did not know who called in. *She had given LPN E a list of what needed to be completed for the residents on the TBI unit that included: -Who was to be checked and changed every two hours. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	-Who needed to have morning cares completed on 9/8/24. She stated that included residents 1, 5, and 8. *When she needed help she would call for assistance. 18. Review of the provider's video footage of TBI unit for 9/7/24 10:00 p.m. through 9/8/24 at 6:00 a.m. revealed: *Resident 2 was in a wheelchair in the dining area. *LPN E arrived at 10:05 p.m. on the TBI unit. *LPN E attempted to give resident 2's medications to him through his G-tube at 10:23 p.m. *LPN E called for assistance, at 10:25 p.m. Medication aide J and LPN K arrived and assist with that medication administration then they exited the TBI unit. *LPN E entered resident 3's room at 10:38 p.m. and exited that room at 10:49 p.m. *LPN E and CNA L entered TBI unit and entered to resident 1's room at 11:02 p.m. *LPN E and CNA L remained in resident 1's room till 11:22 p.m. *CNA L and LPN E repositioned resident 2 from his wheelchair with a total mechanical lift to his room at 11:26 p.m. and exited his room at 11:31 p.m. *CNA L and LPN E entered resident 7's room till 11:36 p.m. then CNA L exited the TBI unit. *LPN E was at a desk in the TBI unit from 11:38 p.m. until 12:40 a.m. when he got up, went and goes to the laundry room and then returned to the desk. *CNA L entered the TBI unit at 1:00 a.m. and entered resident 1's room, he exited that room at 1:08 a.m. with a garbage bag and left the TBI unit. *LPN E sat at a desk from 1:10 a.m. until 2:01 a.m. *CNA G entered the TBI unit checked on resident 1 in his room and then exited the TBI unit. *LPN E returns to a desk from 2:03 a.m. to 2:41 a.m. he then stood, peeks into resident 1 room and returned to a desk. *CNA L entered TBI unit at 2:45 a.m. LPN E exited TBI unit at 2:48 a.m. CNA L walked up and down both hallways and entered resident 5 room at 2:56 a.m. and then exited the room a minute later. *LPN E returned to the TBI unit at 3:08 a.m. and CNA L exited the TBI unit LPN E remained at a desk until 4:25 a.m (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	*LPN E entered resident 6's room and exited at 4:28 a.m. with no garbage bag in hand, LPN E entered laundry room. *LPN E sat at a desk from 4:29 a.m. until 5:34 a.m. when LPN D entered the TBI unit. -LPN E gives report to LPN D. -Observed LPN E and LPN D counting narcotics in the medication cart. *CNA F and CNA L entered TBI unit at 5:51 a.m. CNA L leaves the TBI unit after one minute. *CNA F entered resident 3's room at 6:01 a.m. and then returned to the dining room area. *CNA N entered the TBI unit at 6:04 a.m. for her shift. *CNA N and CNA F entered resident 5's room at 6:10 a.m. *LPN E exited the TBI unit at 6:12 a.m. *CNA N and CNA F are observed talking with LPN D at the desk at 6:23 a.m. 19. Follow-up interview on 9/25/24 at 2:47 p.m. with DON B revealed: *Last rounds were to be completed before 10:00 p.m. *Check and change for incontinence needs would then start approximately at midnight and every two hours after that. *She confirmed residents 1, 2, 3, 5, 7 and 8 had incontinence and needed to be checked and changed every two hours. 20. Follow-up interview on 9/25/24 at 3:43 p.m. regarding the above observations of the video recording with administrator A and DON B revealed: *LPN E was not in resident rooms when he was expected to be. *Cares for residents were not completed as required by staff on the night of 9/7/24 at 10:00 p.m. to 9/8/24 at 6:00 a.m. and according to the residents' care plans. 21. Review of the provider's 1/20/24 LTC Abuse Prohibition Policy revealed: *Neglect the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. *Neglect occurs when the facility is aware of or should have been aware of, goods or services that a resident(s) requires but the facility fails to provide them to the resident(s) . (continued on next page)

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	435100	A. Building B. Wing	09/25/2024

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F 0600 Level of Harm - Actual harm Residents Affected - Some	*Neglect includes cases where the facility's indifference or disregard for resident care, comfort, or safety, results in or may result in physical harm, pain, mental anguish, or emotional distress. *Neglect may be the result of a pattern of failures or may be the result of one or more failures involving one resident and one staff person.

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F 0684 Level of Harm - Actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 50015 Based on South Dakota Department of Health (SD DOH) complaint review, record review, interview, and video review, the provider failed to ensure eight of eight sampled residents (1, 2, 3, 4, 5, 6, 7, and 8) who were dependent on staff for their care needs, received those cares as directed on their care plans. Findings include: 1. Review of the 9/12/24 SD DOH complaint revealed: *The complainant wanted to remain anonymous. *There was concern regarding neglect for all residents in the Traumatic Brain Injury (TBI) unit. *From 9/7/24 at 10:00 p.m. to 9/8/24 at 6:00 a.m. -Resident 5 was left in the same clothes he was dressed in on 9/7/24. -He was curled up in a ball on the floor with no blanket. -He was cold to the touch. -He was covered in feces. -His bed was still made from the previous day. *Residents (1, 2, 3, 7, and 8) were identified as being incontinent of both bowel and bladder in the complaint. *Complainant requested a review of the video footage of the unit. 2. Review of resident 4's electronic medical record (EMR) and pocket care plan revealed: *His diagnoses included: -Cerebral Infarction (stroke) affecting right dominant side. -Aphasia (language disorder). -Atherosclerotic heart disease. *His Brief Interview for Mental Status (BIMS) score was 00 which indicated he had severe cognitive impairment. *He needed 24-hour supervision. *He was at risk for elopement. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Some	*He lacked safety awareness. *He could not express his needs at times due to his speech. *Staff were to anticipate his needs. *He was independent with emotional, intellectual, physical and social needs. *He was continent of bowel and bladder. *He was a full code. 3. Review of resident 6's EMR and pocket care plan revealed: *His diagnoses included: -Cerebral infarction (stroke). -Incontinent of bowel. -Aphasia (language disorder). -Heart disease. *He required the assistance of one staff for most of his activities of daily living (ADLs). *His BIMS score was 9 which indicated he had moderate cognitive impairment. *Staff were to anticipate his needs, due to him rarely expressing his needs, even though he was able to. *He required partial/moderate assistance of one staff with bed mobility, toileting needs, and ADLs. *He was a full code. 4. Interview on 9/25/24 at 8:45 a.m. with administrator A revealed: *Tasks are used for ADL charting. *Provider does not have an ADL Policy. 5. Review of the provider's video footage of TBI unit for 9/7/24 10:00 p.m. through 9/8/24 at 6:00 a.m. revealed: *Resident 2 was in a wheelchair in the dining area. *LPN E arrived at 10:05 p.m. on the TBI unit. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Some	*LPN E attempted to give resident 2's medications to him through his G-tube at 10:23 p.m. *LPN E called for assistance, at 10:25 p.m. Medication aide J and LPN K arrived and assist with that medication administration then they exited the TBI unit. *LPN E entered resident 3's room at 10:38 p.m. and exited that room at 10:49 p.m. *LPN E and CNA L entered TBI unit and entered to resident 1's room at 11:02 p.m. *LPN E and CNA L remained in resident 1's room till 11:22 p.m. *CNA L and LPN E repositioned resident 2 from his wheelchair with a total mechanical lift to his room at 11:26 p.m. and exited his room at 11:31 p.m. *CNA L and LPN E entered resident 7's room till 11:36 p.m. then CNA L exited the TBI unit. *LPN E was at a desk in the TBI unit from 11:38 p.m. until 12:40 a.m. when he got up, went into the laundry room and then returned to the desk. *CNA L entered the TBI unit at 1:00 a.m. and entered resident 1's room, he exited that room at 1:08 a.m. with a garbage bag and left the TBI unit. *LPN E sat at a desk from 1:10 a.m. until 2:01 a.m. *CNA G entered the TBI unit checked on resident 1 in his room and then exited the TBI unit. *LPN E returns to a desk from 2:03 a.m. to 2:41 a.m. he then stood, peeks into resident 1 room and returned to a desk. *CNA L entered TBI unit at 2:45 a.m. LPN E exited TBI unit at 2:48 a.m. CNA L walked up and down both hallways and entered resident 5 room at 2:56 a.m. and then exited the room a minute later. *LPN E returned to the TBI unit at 3:08 a.m. and CNA L exited the TBI unit LPN E remained at a desk until 4:25 a.m *LPN E entered resident 6's room and exited at 4:28 a.m. with no garbage bag in hand, LPN E entered laundry room. *LPN E sat at a desk from 4:29 a.m. until 5:34 a.m. when LPN D entered the TBI unit. -LPN E gives report to LPN D. -Observed LPN E and LPN D counting narcotics in the medication cart. *CNA F and CNA L entered TBI unit at 5:51 a.m. CNA L leaves the TBI unit after one minute. *CNA F entered resident 3's room at 6:01 a.m. and then returned to the dining room area. (continued on next page)

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	09/25/2024

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 0684 Level of Harm - Actual harm Residents Affected - Some	*CNA N entered the TBI unit at 6:04 a.m. for her shift. *CNA N and CNA F entered resident 5's room at 6:10 a.m. *LPN E exited the TBI unit at 6:12 a.m. *CNA N and CNA F are observed talking with LPN D at the desk at 6:23 a.m. *Residents 1, 2, 3, 4, 5, 6, 7, and 8 were not provided care according to their individual care needs. Refer to F600 findings 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, and 20.