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	12/31/2025

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), record review, interview, and policy review, the provider failed to ensure staff followed a resident's documented do not resuscitate (DNR) code status wishes for one of one closed record sampled resident (52) when discovered with no pulse or respirations by staff and was then provided cardiopulmonary resuscitation (CPR) without first verifying the resident's code status. Findings include: 1. Review of the provider's [DATE] SD DOH FRI revealed:*On [DATE] at 5:20 a.m. a nurse obtained resident 52's vitals which were stable, and her blood sugar was reading high both times it was checked and then assisted resident 52 (who had agreed to go to the hospital) to the restroom.*The nurse called the on-call provider to report on resident 52's condition and to receive orders to administer insulin and Zofran (medication for nausea).*A second nurse went to resident 52's room and found her slumped over on the toilet and heard a gurgling noise. The resident's vitals were not able to be obtained. Resident 52 was transferred to the floor where staff started CPR, and applied an AED (automated external defibrillator).*Three nurses performed chest compressions on resident 52. *The director of nursing (DON) B arrived during resuscitation efforts in resident 52's room and informed staff to stop CPR due to the resident having no breath sounds or an apical pulse. The resident's time of death was reported as 7:05 a.m. on [DATE] at the facility. 2. Review of resident 52's closed electronic medical record (EMR) revealed:*She was admitted to the facility on [DATE].*She had an advance directive (a document that expresses a person's health care wishes if they become unable to speak for themselves) signed by her legal representative and physician on [DATE] indicating her resuscitation code status was a DNR/DNI.*There was an active physician's order on [DATE] indicating she was a DNR/DNI. 3. Interview on [DATE] at 8:35 a.m. with DON B and administrator A about the FRI regarding resident 52 revealed:*There were three nurses (licensed practical nurse (LPN) F, registered nurse (RN) K, and LPN DD) involved in the above incident on [DATE]. *The nurses had started CPR on resident 52, checked the code status which was a DNR/DNI, but continued performing CPR.*The nurses involved explained to DON B that they thought since they had already started CPR they were to continue until EMS had arrived.*By the time DON B had arrived and verified that resident 52 was a DNR/DNI the nurses had been performing CPR on resident 52 for about 20 minutes.*DON B and administrator A spoke with the medical director who reported that the staff should have stopped CPR once they confirmed the code status of a resident was a DNR.*On [DATE] DON B conducted a nurses meeting after resident 52's incident where she educated the staff on advance directives and code statuses.*She expected her staff to call for help, grab the crash cart, call a supervisor and the provider, and check the code status in the event a resident was unresponsive.*DON B did not expect the staff to recall a resident's code status and expected the staff to start CPR until they could verify the code status of the resident.*The code statuses of residents were identified in their EMR and on the hall sheets (lists residents' care needs and interventions) that the staff members were to carry with them while they worked.*They stated they had not performed any auditing or monitoring to ensure the residents' code statuses were identified or that the staff were aware of the expectations regarding their processes for providing life sustaining measures according to a resident's code status after resident 52's incident. 4. Interview on [DATE] at 9:45 a.m. with LPN L revealed:*She had started working at the facility in [DATE].*She had received general education regarding advance directives and code status.*She explained she would not start CPR on a resident with a DNR code status if the resident was unresponsive with no pulse or respirations.*Resident code statuses were identified in the EMR and the hall sheets. 5. Interview on [DATE] at 9:57 a.m. with LPN D revealed:*She started working at the facility in [DATE].*Resident code statuses were identified in the EMR and the hall sheets.*In an emergency, she would check a resident's code status before beginning CPR.*She received mandatory education about advance directives and code statuses. 6. Interview on [DATE] at 10:09 a.m. with certified nursing assistant (CNA) J revealed:*She had worked at the facility for about a week.*She was CPR certified. *She watched orientation training videos, but they did not provide education specifically regarding a resident's code status.*Resident's code statuses were identified in the EMR and the hall sheets. 7. DON B was unable to provide signed education documentation of the nursing staff to verify who attended the nurses meeting on [DATE] after resident 52's [DATE] incident. 8. Review of the provider's new hire orientation and annual education for staff revealed they provided education on advance directives and resident code statuses. 9. Review of the provider's reviewed 10/2025 LTC Code Status/Resuscitation policy revealed:* To