| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435100 | A. Building<br>B. Wing | 05/05/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sunset Manor Avera Health | 129 E Clay St<br>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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, observation, interview, and policy review the provider failed to protect the residents' right to be free from physical abuse for one of one sampled resident (1) who was straddled and restrained in his bed by one of one certified nursing assistant (CNA)G while he provided incontinence (involuntary urine and bowel leakage) care to resident 1. Findings include:1. Review of the provider's SD DOH FRI report dated 3/23/26 revealed that resident 1 had a Brief Interview for Mental Status (BIMS) assessment score of 99, which indicated his cognition was severely impaired. The report indicated that on 3/22/26 at 4:00 a.m., resident 1 became combative during incontinence care provided by CNA G. During the interaction, CNA G straddled resident 1 in his bed to manage the resident's combative behavior and applied pressure with his thumb to a pressure point behind the resident's ear to calm the resident. This action increased the resident's combative response, and CNA G provided incontinent care while the resident was restrained. 2. Review of resident 1's electronic medical record (EMR) revealed he was admitted to the facility on [DATE]. His diagnoses included neurocognitive disorder with Lewy Bodies (progressive brain disorder characterized by abnormal protein deposits that cause cognitive decline, visual hallucinations, movement issues, and fluctuating alertness), dementia (a group of symptoms affecting memory, thinking, and social abilities) with behavioral disturbances and anxiety (anticipation of future changes or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). His care plan indicated he had memory problems and became confused easily, and staff were to encourage and assist him in making safe decisions regarding his care and personal relationships by giving him safe and simple choices. He wore incontinent products (briefs) for dignity and protection, and staff were to assist him with incontinent care with each incontinent episode. 3. Observation on 5/5/26 at 10:15 a.m. of resident 1 revealed he was asleep in his bed and unable to be interviewed. 4. Interview on 5/5/26 at 10:10 a.m. with director of nursing (DON) B revealed that CNA G reported the incident to licensed practical nurse (LPN) C at approximately 6:00 a.m. on 3/22/26 during the morning shift report (the communication given by the staff who are ending their shift to the incoming staff before the new shift begins. It includes essential information about each patient's current status, recent changes, important events from the previous shift, ongoing concerns, and tasks that need followˆup. The purpose is to ensure continuity of care, maintain patient safety, and keep the oncoming staff fully informed). LPN C then reported the incident to nurse manager (NM) E, who subsequently notified the minimum data set (MDS) nurse F. CNA G returned for his scheduled night shift on 3/23/26 and provided direct resident care. MDS nurse F reported the incident to administrator A and DON B on 3/23/26 through the FRI reporting process and an email. DON B suspended CNA G on 3/23/26 pending the outcome of the facility's investigation. During the investigation, DON B interviewed LPN C, NM E, and MDS nurse F, who confirmed that the interaction between CNA G and resident 1was reported by CNA G. DON B ensured the resident's medical provider and representative were notified of the incident. 5. Interview on 5/5/26 at 1:41 p.m. with LPN C revealed that on 3/22/26, around 6:00 a.m. CNA G indicated that resident 1 was<br>(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 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | combative while he provided his care. CNA G used the term straddle the resident when he described how he managed the resident's behavior when he cleaned stool from the resident's perineal area (the region of the body between the thighs, including the area from the genitals to the anus). He also reported that he had placed pressure behind the resident's ear to distract him when he completed the care. LPN C assessed the resident and did not find any injuries on resident 1's body.She reported the information to her supervisors, NM E, and MDS nurse F, both of whom were in the facility after she had received the report. LPN C stated this was the first time she had heard of an incident of this nature and now understands she was required to notify the DON and complete a report to the SD DOH. 6. Interview on 5/5/26 at 3:08 p.m. with CNAs D and H revealed they each had received training on abuse and neglect, resident rights, and dementia care. CNA H indicated that she had a criminal background check completed, and she had to sign an abuse affidavit before she was allowed to work at the facility. CNA H and CNA D indicated they had no concerns regarding any staff member regarding abuse or neglect. They denied any family members sharing a concern, such as abuse to her, but indicated they would go to their DON or nurse if there was a concern. 7. Review of NM E's personnel file revealed she was placed on leave on 3/23/26, and her employment with the facility was terminated on 3/24/26. She received annual training on 9/11/25 and 9/15/25 that included abuse and neglect, resident rights, and dementia care. An abuse affidavit was completed when she was hired, and a criminal background check was completed that had no remarkable findings. 8. Review of MDS nurse F's personnel file revealed she was placed on leave on 3/23/26, and her employment with the facility was terminated on 3/25/26. She received annual training on 9/8/25 that included abuse and neglect, resident rights, and dementia care. An abuse affidavit was completed when she was hired, and a criminal background check was completed that had no remarkable findings. 9. Review of CNA G's personnel file revealed he was hired on 9/25/25 and his employment with the facility was terminated on 3/25/26. He received training on 9/25/25 that included abuse and neglect, resident rights, and dementia care. An abuse affidavit was completed when he was hired, and a criminal background check was completed that had no remarkable findings. 10. Review of the provider's January 2024 Long Term Care Abuse Prohibition Policy revealed, It is essential for facilities to prohibit and prevent abuse, neglect, exploitation of residents, misappropriation of resident property, corporal punishment, and involuntary seclusion, including freedom from physical or chemical restraints not required to treat a resident's medical symptoms. The facility will have systems in place to encourage and support all residents, staff, families, visitors, and resident representatives in reporting any suspected acts of abuse, neglect, or exploitation of residents, misappropriation of resident property, corporal punishment, and involuntary seclusion. The term abuse (indicates any type of abuse, i.e., sexual abuse, staff to resident, resident to resident, visitor to resident, physical, mental, verbal, deprivation of goods and services, neglect, exploitation, involuntary seclusion, misappropriation of resident property, and corporal punishment) will be used throughout this policy unless specifically indicated. An owner, licensee, administrator, manager, employee, agent, contractor, or volunteer of a nursing home shall not physically, mentally, or emotionally abuse, mistreat, or neglect a resident. All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately to the administrator. All owners, operators, employees, managers, agents, or contractors must report to the State Agency and one or more law enforcement entities any reasonable suspicion of a crime against an individual who is a resident of or is receiving care from the facility. No later than 24-hours if the event did not result in serious bodily injury. Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Physical abuse includes, but is not limited to, hitting, slapping, pinching, and kicking. Corporal punishment, which is physical punishment, is used as a means to correct or control behavior. Corporal punishment includes, but is not limited to, pinching, spanking, slapping of hands, flicking, or hitting with an object. Convenience: is defined as the result of any action that has the effect of<br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | altering a resident's behavior such that the resident requires a lesser amount of effort or care and is not in the resident's best interest. Freedom of movement means any change in place or position for the body or any part of the body that the person is physically able to control. Physical restraint is defined as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria, cannot be removed easily by the resident; and restricts the resident's freedom of movement or normal access to his/her body. |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, and policy review, the provider failed to report a physical abuse incident to the SD DOH within the required time frame for one of one sampled resident (1), who was straddled and restrained in his bed by one of one certified nursing assistant (CNA) (G) while he provided incontinence (involuntary urine and bowel leakage) care to resident 1. Findings include: Findings include: 1. Review of the provider's 3/23/26 SD DOH FRI (a required reporting of unexpected or adverse events) report revealed that on 3/22/26 at 4:00 a.m., resident 1 was combative during morning care rounds (changing of residents who were incontinent of stool or urine). CNA G had turned the resident so he was positioned on his side, lying in his bed. That increased the resident's combative behavior, so CNA G placed a leg over the resident to straddle him. CNA G then used his thumb and put pressure on a pressure point under the resident's ear (to lock the resident's jaw) to distract the resident. This increased resident 1's combative behavior, but allowed CNA G to complete the incontinence care for resident 1. CNA G reported this incident to licensed practical nurse (LPN) C at 6:00 a.m. on 3/22/26 during the morning shift report (report to the oncoming staff about resident care). LPN C reported the incident to nurse manager (NM) E, who then reported it to the minimum data set (MDS) nurse F. An incident report was completed by LPN C on 3/22/26 and placed under DON B's office door. The incident occurred over the weekend, and DON B was not in the facility. LPN C asked MDS nurse F if DON B should be called to notify her of the incident. She was told by MDS nurse F that an email was sent to DON B. The email was sent by MDS nurse F to DON B on 3/22/26 at 2:52 p.m., before she had left for the day. CNA G returned to work on 3/23/26 for his next scheduled night shift and provided direct contact care for the residents. 2. Interview on 5/5/26 at 10:10 a.m. with DON B revealed on 3/23/26, she became aware of the alleged abuse incident that involved resident 1 and CNA G. She indicated the incident occurred on 3/22/26 at 4:00 a.m. during the resident's morning incontinence cares, and CNA G reported it to LPN C before he left the facility after his scheduled shift. DON B had indicated that the incident had not been reported to the SD DOH in the required time frame. DON B stated resident 1 was combative when CNA G was providing resident 1's incontinence care. CNA G had stated he straddled the resident in the resident's bed to hold him down so he could clean stool from the resident's perineal area (the region of the body between the thighs, including the area from the genitals to the anus). Resident 1 remained combative with CNA G, so CNA G put pressure on a pressure point area behind the resident's ear to distract him from moving. CNA G returned to work on 3/23/26 for his scheduled night shift, since0 the incident was not reported to the DON B or administrator A as it should have been. She completed the incident reporting to the SD DOH on 3/23/26, but she did not report the incident to the Department of Human Services (DHS). She indicated that there were previous incidents involving other residents that she had reported to DHS, but she never heard back from the DHS, or if she did, they told her they were not concerned because the resident was in a safe place. 3. Interview on 5/5/26 at 1:41 p.m. with LPN C revealed on 3/23/06 at 6:00 a.m., during morning report with CNA G, he reported he had straddled resident 1 during his incontinence cares because the resident was being combative. CNA G told her he then used his thumb to put pressure on a pressure point behind the resident's ear to calm him down. CNA G indicated that the resident became more combative after he had done that, but he was able to get the job done. She assessed resident 1 after receiving the report of the incident from CNA G, and no injuries were found on resident 1's body. She reported the incident to NM E, who then reported the incident to the MDS nurse F, as she was the management nurse that day. LPN C had asked NM E and MDS nurse F if CNA G should return for his scheduled night shift on 3/23/26. She indicated that both NM E and MDS nurse F reported that they had filled out an incident report, placed it under DON B's office door, and sent her an email to inform her of the incident. 4. Interview on 5/5/26 at 1:08 p.m. with DON B revealed she<br>(continued on next page) |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | expected that if an alleged violation involving resident abuse or neglect occurred, she would be notified immediately. 5. Review of the provider's 1/2024 Long Term Care Abuse Prohibition Policy revealed, It is the policy of the facility that abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion allegations are reported according to Federal and State Laws. The facility will ensure that all alleged violations involving abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion are reported immediately to the administrator. All alleged violations of abuse, neglect, exploitation of residents, misappropriation of resident property, injuries of unknown origin, corporal punishment, and involuntary seclusion must also be reported by the facility to officials in accordance with State law, including the State Survey Agency and adult protective services where State law provides for jurisdiction in long-term care facilities. Immediately, but no later than 2 hours if the alleged violation involves abuse or results in serious bodily injury. Facility initial reporting of allegations: For all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, the administrator or designee will notify officials in accordance with State law, to include the State Survey Agency and adult protect services where state law provides for jurisdiction in long-term care facilities immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury or no later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury. Department of Human Services (DHS) Notification: only for an incident or event where there is reasonable cause to suspect abuse or neglect of any resident by any person. |