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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, interview, and facility assessment review, the provider failed to post the required nursing staffing information in a location readily visible to residents, staff, and visitors that clearly reflected actual hours worked by the nursing staff from October 2025 through December 2025 daily:*For 46 of 92 days reviewed regarding the Traumatic Brain Injury unit (TBI).*For 24 of 92 days reviewed regarding the Challenging Behavior Unit (CBU).*For 13 of 92 days reviewed regarding the main area where residents resided (The Manor). Findings include:1. Observation on 12/29/25 at 2:34 p.m. of the provider's posted nurse staffing hours for The Manor and the CBU revealed:*The information was posted on a bulletin board near the nurses' station in the Manor.*It included the date of 12/26/25 and resident census for The Manor and the CBU.*There were no registered nurse (RN) hours documented on those postings.2. Observation on 12/29/25 at 3:45 p.m. in the TBI unit revealed there were no posted nurse staffing hours.3. Observation on 12/31/25 at 9:28 a.m. of the provider's 12/31/25 posted nurse staffing hours for The Manor and the CBU revealed there were no RN hours documented for that day.4. Review of the posted nurse staffing hours from 10/1/25 through 12/31/25 revealed there were no nurse staffing information forms for:*The Manor on 10/10/25, 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, 12/27/25, 12/28/25, and 12/29/25.*The TBI unit on 10/1/25, 10/3/25, 10/7/25, 10/11/25, 10/12/25, 10/13/25, 10/16/25, 10/17/25, 10/21/25, 10/29/25, 11/1/25, 11/2/25, 11/3/25, 11/6/25, 11/7/25, 11/11/25, 11/14/25, 11/18/25, 11/20/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, 12/2/25, 12/3/25,12/8/25, 12/10/25, 12/11/25, 12/13/25, 12/14/25, 12/15/25, 12/18/25, 12/19/25, 12/23/25, 12/24/25, 12/25/25, 12/26/25, 12/27/25, 12/28/25, and 12/29/25.*The CBU on 10/23/25, 10/24/25, 10/25/25, 10/26/25, 10/27/25, 10/28/25, 10/29/25, 10/30/25, 10/31/25, 12/10/25, 12/11/25, 12/12/25, 12/13/25, 12/14/25, 12/15/25, 12/16/25, 12/17/25, 12/18/25, 12/19/25, 12/20/25, 12/21/52, 12/27/25, 12/28/25, and 12/29/25.5. Review of the posted nurse staffing hours from 10/1/25 through 12/31/25 revealed there were no documented RN coverage hours for 10/7/25, 10/23/25, 10/27/25, 11/12/25, 11/24/25, 11/25/25, 11/28/25, 12/3/25, 12/4/25, 12/8/25, 12/11/25, 12/13/25, 12/14/25, 12/17/25, 12/18/25, 12/22/25, 12/23/25, 12/26/25, 12/30/25, and 12/31/25.6. Review of the provider's nurse staff schedules from 12/13/25 through 12/31/25 revealed:*On 12/13/25 RN/Minimum Data Set (MDS) coordinator C was scheduled to work, and those hours were not represented on the posted nurse staffing hours.*On 12/14/25 RN/assistant director of nursing (ADON) FF was scheduled to work, and those hours were not represented on the posted nurse staffing hours.*On 12/18/25 RN/ADON FF was scheduled to provide resident care from 8:00 a.m. until 11:30 a.m. and director of nursing (DON) B was scheduled to provide resident care from 11:30 a.m. until 6:00 p.m. due to an LPN that was identified on the nurses' schedule to have called in sick.-The posted nurse staffing hours were not updated to reflect that change.7. Review of the posted nurse staffing forms and interview on 12/31/25 at 10:43 a.m. with LPN D on the TBI unit revealed:*The posted nurse staffing hours were posted on a bulletin board behind a desk in the unit's common area.*LPN D stated the posted nurse staffing hours were to be completed each day, but she did not know who completed them.*She did not change the information on the posted nurse staffing if (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
	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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	there were changes in the staffing during her shift.*She verified the nurse assigned to the CBU and TBI unit shared their scheduled hours between the two units, but the TBI unit posted nurse staffing form identified the nurse was scheduled on that unit for the entire 12-hour shift, which was inaccurate.*LPN D agreed the location of the posted nurse staffing hours in the TBI unit was not readily visible for residents or visitors.8. Interview on 12/31/25 at 1:42 p.m. with administrator A revealed:*The night shift nurse was responsible for completing the daily nurse staffing hours form for the next day according to the staff schedule and resident census and was to post them in each unit.*She expected that the posted nurse staffing hours would be updated each shift if there was a staffing change by the nurse on duty in that unit.*She expected the hours on the posted staffing to be accurate. She agreed the nurse hours documented on those forms for the TBI unit and the CBU were not accurate.9. Interview on 12/31/25 at 3:09 p.m. with director of nursing (DON) B revealed:*The posted nurse staffing hour forms were to be completed by The Manor night shift nurse and posted on each unit.*The MDS coordinator and the DON hours were not included on the posted nurse staffing hours forms.*She verified that she and the MDS coordinator assisted with resident care needs.*She verified the MDS and DON hours were submitted as RN coverage hours in the Payroll Based Journal (PBJ) reporting system.*The posted nurse staffing hours were to be posted daily and were to be accurately reflect the hours worked by each staff member.*She agreed there were missing posted nurse staffing hour forms for all three units.*She agreed that the staff did not update the posted nurse staffing forms to represent an accurate number of hours worked for each shift.*She agreed the LPN and RN hours posted for the CBU and TBI units did not accurately represent that the nurses split scheduled 12-hour shifts between the two units.*She expected the posted nurse staffing hours to be completed accurately and posted in a location that was visible for residents, staff, and visitors.10. Review of the provider's 4/2/25 Facility Assessment revealed:*Staffing Plan Nursing, nutrition services and housekeeping staffing is evaluated at the beginning of each sift [shift] and adjusted as needed to meet the care needs and acuity of the resident population. See the posted nursing staffing hours for details. CBU:Charge Nurse: 5:30a [a.m.]- 6p [6:00 p.m.], 5:30p-6a (shared with TBI). TBI:Charge Nurse: 5:30a [a.m.]- 6p [6:00 p.m.], 5:30p-6a (shared with CBU).* Support Staff:Director of Nursing: Monday thru Friday 7am [7:00 a.m.] -5p. [5:00 p.m.]MDS Coordinator, RN: Monday thru Friday 8am-4:30pm.* At the minimum there is one RN/LPN in [the] facility at all times for 24h [24 hour] nursing coverage (8 hour RN coverage at minimum).

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 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** Based on record review, interview, and policy review, the provider failed to ensure six of six sampled residents' (2, 6, 9, 34, 39, and 40) with a severe mental health illness Minimum Data Set, a tool used to evaluate a resident's health status and to develop an individualized care plan to manage the resident's care needs, (MDS) assessments were accurately coded for the area of Pre-admission Screening and Resident Review (PASRR).Findings include: 1. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His diagnoses included bipolar (mental condition causing extreme shifts in mood, energy, and activity levels), and neurocognitive disorder (a group of conditions marked by the decline in mental function like memory, thinking, and reasoning) and psychotic disorder (a loss of contact with reality characterized by symptoms like delusions (false beliefs) and hallucinations (seeing, hearing, feeling things that are not true)). *He had a level I (1) PASRR completed on 9/5/25 for a potential change in condition that stated. -Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation. -The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?' *There was Level II PASRR in resident 2's EMR dated 1/18/23. *Item A1500 of his 10/9/25 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 2. Review of resident 6's EMR revealed: *She was admitted on [DATE]. *Her diagnoses included depression, anxiety disorder (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), and psychotic disorder. *She had a level I PASRR completed on 9/5/25 for a potential change in condition that stated. -Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD (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	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment needs have not significantly changed since your previous PASRR Level II evaluation. -The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?' *There was no Level II PASRR in resident 6's EMR. *Item A1500 of his 5/8/25 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 3. Review of resident 9's EMR revealed: *She was admitted on [DATE]. *Her diagnoses included depression, anxiety disorder, psychotic disorder, and schizophrenia (a severe brain disorder causing distorted reality perception, featuring hallucinations, delusions, disorganized thinking, and reduced emotional expression). *She had a level I PASRR completed on 7/24/25 for a potential change in condition that stated. -Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation. -The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?' *There was a Level II PASRR in resident 9's EMR dated 11/14/18. *Item A1500 of his 2/28/25 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 4. Review of resident 34's EMR revealed: *She was admitted on [DATE]. *Her diagnoses included depression, anxiety disorder, and bipolar disorder. *There was a Level II PASRR in resident 34's EMR dated 7/14/23. *Item A1500 in of his 7/6/25 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? (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	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of resident 40's EMR revealed: *She was admitted on [DATE]. *Her diagnoses included depression, anxiety disorder, and psychotic disorder. *She had a level I PASRR completed on 9/5/25 for a potential change in condition that stated. -Your Level I screen was submitted for a potential status change. It shows that you have evidence of serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD treatment needs have not significantly changed since your previous PASRR Level II evaluation. -The facility should mark yes for question A1500 on the MDS 'Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or related condition?' *There was a Level II PASRR in resident 40's EMR dated 3/11/25. *Item A1500 of his 3/31/25 comprehensive MDS assessment was coded No to the question Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition? 6. Review of resident 39's EMR revealed: *He was admitted on [DATE]. *He had diagnoses of Parkinson's disease (a brain disorder that slowly worsens over time leading to symptoms of shaking, stiffness, slow walking, balance issues, and potential problems with sleep, mood and thinking), dementia (a group of symptoms affecting memory, thinking and social abilities), major depressive disorder (a serious mood disorder where intense sadness, hopelessness, and loss of interest in life for at least two weeks, making it hard to do daily things) (MDD), and anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability). *He had current physicians orders for clozapine (an antipsychotic [a medication that alters the activity of neurotransmitters in the brain to reduce symptoms of psychosis (a state of losing touch with reality) and duloxetine (an antidepressant medication). *His 3/4/25 and 6/11/25 PASRR level I screen outcomes indicated he had a positive level I, and no status change. -His PASRR conditions were serious mental illness. -His 6/11/25 PASRR outcome explanation stated: - Your Level 1 Screen was submitted for a potential status change. It shows you have evidence of a serious mental illness or an intellectual/developmental disability (IDD). However, your condition does not require further PASRR evaluation at this time because your serious mental illness or IDD (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	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	treatment needs have not significantly changed since your previous PASRR Level II evaluation. If your needs change, a new Level 1 screen should be submitted by your health care provider. Unless your needs change, your [NAME] Level II Summary of Findings remains valid during your stay at the nursing facility and should transfer with you if you move to a different nursing facility. You require no further Level 1 screening unless you experience a significant change in serious mental illness or IDD treatment needs. -Since this evaluation has determined that you have a PASRR condition, if you admit to a Medicaid-certified nursing facility .the facility will need to document your PASRR condition in important Medicaid nursing facility paperwork. The facility should mark yes for questions A1500 on the Minimum Data Set, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition? Also, your specific PASRR condition(s) should be checked in question A1510, Level II 'Preadmission Screening and Resident Review (PASRR) Conditions.' -His 10/9/25 comprehensive MDS assessment, question A1500, Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition? was marked No. -Item A1500 was coded No on his 10/25/24 and11/21/24 comprehensive MDS assessments. 7. Interview on 12/31/25 at 1:18 p.m. with social service designee (SSD) H revealed she: *Had just started in the SSD position in August. *Was responsible for submitting the PASRR screens to Maximus (the state contracted agency responsible for reviewing, making determinations, and recommendations related to residents' PASRR screening results). *Submitted PASRR screens to Maximus for review on any resident with a mental health medication change or a new mental health diagnosis for evaluation. *Did not enter the PASRR information into the residents' MDS assessments. *Verified residents 2, 6, 9. 34, 39, and 40 had level II PASRRs according to the information provided by Maximus. *Agreed that if a resident's level II PASRR was not present in their EMR she would not be able to determine if the PASRR II recommended services were being provided. 8. Interview on 12/31/25 at 1:42 p.m. with administrator A revealed: *Registered nurse (RN)/MDS coordinator C was responsible for coding the PASRR information in the residents' MDS assessments. -RN/MDS coordinator C was not available for an interview during the survey. *Administrator A expected the residents' MDS assessments to be coded accurately. (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	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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9. A review of the provider's 1/2025 LTC Resident-Assessment-Instrument (RAI)-System Standard policy regarding MDS completion revealed: *All persons who have completed any portion of the MDS Resident Assessment Form must sign the document attesting to its accuracy. *The Assessment Coordinator is responsible for electronically transmitting encoded, accurate, and complete MDS data to the CMS [Center for Medicare and Medicaid Services]

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, record review, and policy review the provider failed to ensure the staff followed standard food safety practices regarding:*Monitoring the food and drink temperatures prepared and served were served to residents by cook M, P and Q and dietary assistant (DA) N on one of one evening meal services and one of one lunchtime meal services.*Handwashing and glove use by DA N and O and Cooks P and Q was followed during one of one evening meal service and one of one lunch time service in the kitchen. Findings include:1. Interview on 12/29/25 at 3:17 p.m. with resident 48 in her room revealed:*She stated the food was not prepared well.*At times the food is overcooked and at times it is cold.*She stated that there were multiple residents who did not eat their meals due to how the food was prepared and served.*She had reported her concerns to staff members but they were not the staff members who had the authority to do anything about her concerns.2. Observation on 12/29/25 at 5:23 p.m. from of the residents' meal trays in the kitchen revealed the residents' drinks were pre-poured and stored on individual resident trays on an open sided cart.3. Observation and interview with DA N on 12/29/25 at 5:32 p.m. from the dining room of the residents' during the evening meal service revealed:*With only a few resident trays left to be served, DA N was requested to measure the temperature of the milk.*DA N asked cook M how to measure the temperature of the milk.*Cook M removed a thermometer out of the sink, put hand sanitizer on the thermometer, wiped the thermometer off and gave it to dietary assistant N.*DA N measured the temperature of the milk with that thermometer and stated it was 53.6 degrees Fahrenheit (F).*When asked what the temperature of the milk was supposed to be DA N stated he would have to refer to dietary manager (DM) R.*Cook M stated the milk needed to remain between 36- and 40-degrees F for safe consumption.*DM R dumped that glass of milk out and instructed cook M to dump out all the remaining poured prepared of milk on the trays to pour new glasses of milk.4. Observation on 12/29/25 at 5:40 p.m. of DA N in the kitchen and dining room revealed:*He handled dirty linens from the kitchen and dining room with his bare hands.*With those same bare hands, he handled three glasses with his fingers by the tops inside glasses, poured milk into those glasses and then placed them on the residents' meal trays to be served to the residents.5. Observation on 12/30/25 at 11:07 a.m. of cook P in the kitchen revealed:*Cook P put on gloves without washing her hands.*She then picked up the blender that contained pureed foods, used those same gloved hands and a spatula to pour the pureed food into the tray to be placed in the steamer, wiped the pureed foods from the side of the container with her gloved hands, and placed the container in the steamer.*She removed and discarded her gloves, and did not wash her hands. With her bare hands she removed a container of coleslaw, and a container of ham spread from the refrigerator, put them on the counter, and entered the pantry that was attached to the kitchen. When she returned to the kitchen, she did not wash her hand and then put on a pair of gloves.*With those hands cook P poured ice into containers for the coleslaw container to be stored on, removed her gloves, did not wash her hands, and gathered thermometers and alcohol wipes to check the holding temperatures of the prepared foods.6. Observation and interview on 12/30/25 at 11:22 a.m. of cook P as she checked the temperatures of the residents' prepared food items revealed:*She washed her hands and put on a pair of gloves.*She checked the temperatures of all of the food that were stored in the steam table.*Cook P did not take the temperature of the fries under the heat lamp or the assorted pieces of chicken in the warmer.*Cook P placed a chicken [NAME] from that on a resident's meal tray it was served to the resident.*Cook P was asked to take the temperature of the chicken pieces. The temperatures of the chicken drummies were 130 degrees F.*Cook P then placed all the chicken pieces back into the oven.*Cook P verified she should have checked the temperature of the chicken pieces prior to serving them to the residents.*Cook P verified the dietary staff were supposed to check the temperatures of (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	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the food items to be sure the food was cooked and stored at a safe temperature before serving the food to the residents.7. Observation on 12/30/25 at 11:45 of cook Q revealed:*She did not perform hand hygiene and then began placing covers over the chocolate cake with whipped topping.*One of the pieces of caked tipped over and the whipped topping handed on cook Q's hand.*Cook Q tipped the cake back up with her bare hand, put a cover on the cake, and washed her hands8. Observation on 12/30/25 at 11:52 a.m. in the kitchen during the meal service revealed:*Cook P had gloves on and retrieved a knife from the magnet on the wall.*With those same gloved hands, she held a chicken breast with one hand as she cut the chicken breast into pieces.*DM R instructed [NAME] P to use a fork to cut up the chicken breast.*Cook P covered the plate of chicken with an insulated cover, placed it on a resident's meal tray.*Cook P used those same gloved hands to grab a bowl from the shelf by the inside and the top of the bowl. She dished soup into that bowl and placed the bowl of soup on a resident's meal tray.*At 12:00 p.m. pre-poured cold drinks were removed from the refrigerator, placed on the individual resident trays, and stored on an open sided cart in the kitchen.*Cook P again plated a resident's meal that included chicken breast with the same process observed above and she prepared two more meal trays with those same gloves on.*Cook P touched the resident's plated mashed potatoes with those same gloved hands while cutting another chicken breast to serve to the resident.*With those same gloved hands [NAME] P touched and moved potato wedges to the side of to serve to the resident and [NAME] touched a chicken breast while she cut it into pieces.*With those same gloved hands cook P moved a chicken piece to the side of a resident's plate to make room other food items.*With those same gloved hands [NAME] P picked up a piece of breaded chicken pulled it into pieces and served it to the resident. She continued to touch several other food items with those same gloved hands as she plated the residents' meals.9. Observation and interview on 12/30/25 at 12:25 p.m. of lunch meal service with cook Q revealed:*Cook Q was asked to take the temperature of the last milk being served.*Cook Q stated the milk was 50 degrees F and dumped out the milk and poured new glasses of milk to serve to the residents.10. Interview on 12/31/25 at 9:33 a.m. with DA O revealed:*Gloves were to be worn when handling ready to eat foods.*Hands should be washed entering or leaving the kitchen and before putting on gloves and after taking gloves off.11. Observation on 12/31/25 at 9:51 a.m. of DA O in the kitchen revealed:*With gloved hands DA O prepared lettuce salads, handled dirty dishes, and put sandwich meat into a plastic container.*She removed those gloves, did not wash her hands, and put cheese and lettuce salads into the refrigerator.*With her unwashed bare hands, she handled dirty dishes, picked up trash off the floor, and then wiped off the counter where she had prepared food.12. Review of the provider's October 2025 through December 2025s food temperature log revealed:*There were no documented temperatures of the prepared food items that were to be plated and served to the residents.*There were no documented temperatures of hot or cold drinks to be served to the residents.13. Interview on 12/31/25 at 2:40 p.m. with DM R revealed:*She expected gloves to be worn by the staff when handling ready to eat foods.*Gloves should be removed and discarded when they were visibly soiled, and hands should be washed before putting on gloves and after removing gloves.*She expected staff to use clean gloves or clean hands to prepare and serve resident's meals.*Staff were to wash their hands when they entered the kitchen, and after using the bathroom.*The food temperatures were to be checked when it was done cooking ensure it was completely cooked and then prior to serving to ensure it was held at a safe temperature.*She verified staff only documented the cooking temperatures of food and not the holding temperatures.*She verified she could not be sure the holding food temperatures had been taken or within the safe holding temperature ranges if they were not documented.*She verified that the temperatures of the milk and chicken on 12/29/25 and 12/30/25 did not meet the safe temperature ranges.14. Review of the provider's 2023 Food Temperatures policy revealed:* The temperatures of all food items will be taken and properly recorded prior to the service of each meal.1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 [degrees] F.* Hot food items may not fall below 135 (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	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[degrees] F after cooking, unless it is an item which is to be rapidly cooled to below 41 [degrees].* Temperatures should be taken periodically to assure hot foods stay above 135 [degrees] F and cold foods stay below 41 [degrees] F during the holding and plating process and until food leaves the service area.* Food preparation areas will follow these methods:a. Hold foods at or below 41 [degrees] F for cold foods and at or above 135 [degrees] F for hot food (to keep out of the temperature danger zone.Review of the provider's 2023 Bare Hand Contact with Food and Use of Plastic Gloves policy revealed:* Single use gloves or other barriers will be used when handling food directly with hands to assure that bacteria are not transferred from the food handlers' hands to the food product being served. Barehand contact with food is prohibited.* Staff will use clean barriers such as single use gloves, tongs, deli paper and spatulas when handling foods.* Gloved hands are considered a food contact surface that can become contaminated or soiled. If used, single use gloves shall be used for only on task such as working with ready-to-eat (RTE) food or with raw animal food, used for no other purpose and discarded when damaged or soiled, or when interruptions occur in the operation.* Hands are to be washed when entering the kitchen and before putting on single use gloves (before beginning work with food) and after removing single use gloves.* Clean gloves are to be used when:a. Handling ready-to-eat foods.f. Anytime hands would otherwise touch food directly.* Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed and hands must be washed:.During food preparation, as often as necessary to remove soil and contamination and prevent cross contamination when changing tasks.After engaging in other activities that may possibly contaminate the hands with bodily fluids.Any time a contaminated surface is touched.* Hands should be washed after removing gloves.

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure infection control practices were followed regarding: *Cleaning of mechanical lifts and slings by three of three certified nursing assistants (CNA) (W, Z, and AA) observed while transferring three of three sampled residents (9, 24, and 25).*Hand hygiene completed by five of five CNAs (W, X, Z, BB, and CC) observed when assisting three of three sampled resident (17, 24, and 50) with cares.*Hand hygiene completed by two of two CNAs (W and Y) observed assisting five of five sampled resident (1, 9, 16, 25, and 40) to eat. *Use of personal protective equipment by two of two CNAs (X and AA) while providing resident care to one of one sampled resident (24) who was on enhanced barrier precautions (EBP). Findings include: 1. Observation on 12/29/25 at 2:24 p.m. in the common area of the Challenging Behavior Unit (CBU) revealed: *There was a sling made of cloth material draped over the sit-to-stand mechanical lift (a mechanical lift used to assist from a seated to a standing position) in the hallway. *There were no disinfectant wipes available for use on the mechanical lift. *Certified nursing assistants (CNAs) W and Z pushed the sit-to-stand lift in front resident 9's recliner, put the sling that was draped over the lift behind resident 9, and assisted her to a standing position. -While resident 9 was raised to a standing position with the sit-to-stand lift her shirt lifted and the strap of the sling came in direct contact with her skin. *CNAs W and Z did not clean the lift or perform hand hygiene (handwashing) after using the sit-to stand lift to assist resident 9. *CNAs W brought the sling that was used for resident 9 to resident 25's recliner. As she was bringing the sling to resident 25's recliner she dragged the strap of the sling on the floor. *CNAs W and Z placed that sling behind resident 25 and assisted him into his wheelchair while using the sit-to-stand lift. *CNA Z draped the sling back over the sit-to-stand lift and placed the lift in the hallway and did not clean the lift. *Without having performed hand hygiene CNA W assisted resident 9 to a dining table. *Without performing hand hygiene CNA W put on gloves and gave resident 25 Oreo cookies. *CNA W removed her cloves, did not perform hand hygiene, and gave resident 16 a can of pop from the refrigerator and a cookie. *CNA W wiped her nose with the back of her bare hand, did not perform hand hygiene. She then put on a pair of gloves, and assisted resident 9 with eating a donut. (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*CNA W removed her left glove, rolled the glove into the palm of her hand, and with her right gloved hand continued to assist resident 9 with eating a donut. *While holding the soiled glove in her left hand, CNA W used her left hand to assisted resident 40 to drink pop. *CNA W used her ungloved left hand with the soiled glove in it to lift the lid on the garbage can for a resident, did not perform hand hygiene, and then assisted resident 9 to drink pop. *CNA W then removed the glove from her right hand discarded both gloves and did not perform hand hygiene. *While CNA Y was assisting resident 1 with eating yogurt, she removed her gloves, and did not perform hand hygiene, and continued assisting residents eat their snacks. 2. Observation on 12/29/25 at 3:07 p.m. outside resident 25's room revealed: *There was a sign on the outside of his door that indicated he was on enhanced barrier precautions (EBP) which required glove and gown use when providing contact care. *The EBP sign from the Centers for Disease Control and Prevention (CDC), which hung outside of resident 25's door revealed: -It stated, everyone must: clean their hands, including before entering and when leaving the room. -Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities. -dressing -bathing/showering -Transferring -changing Linens -providing hygiene -changing briefs or assisting with toileting -device care or use. -wound care: any skin opening requiring a dressing. *There were gowns and gloves hanging on his door and available for use. (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 25's electronic medical record revealed he was on EBP due to a recurring infection to his elbow and a history of Methicillin-resistant Staphylococcus aureus, a bacteria that is resistant to several common antibiotics that spreads from direct contact or contact with contaminated surfaces (MRSA). 3. Observation on 12/29/25 at 4:32 p.m. in The Manor common area of CNA X revealed: *CNA X did not wash his hands and then put on a pair of gloves. *He put foot pedals on resident 17's wheelchair, removed his gloves, did not perform hand hygiene, and then went into resident 24's room to prepare resident 24 to transfer out of his bed. 4. Observation on 12/29/25 at 4:50 p.m. of CNA s X and AA in resident 24's room revealed: *There was a sign on the outside of his door that indicated he was on EBP. *There were gowns and gloves hanging on the outside of resident 24's door. *CNAs X and AA entered resident 24's room, did not apply gowns, used the manual full body lift (a lift and sling used to lift a person's full body), and transfer resident 24 from his bed to his wheelchair. *CNA AA did not clean the full body lift and pushed it into an unoccupied resident room used for storage and left it in that room. 5. Observation and interview on 12/30/25 at 10:58 a.m. with CNAs BB and CC, in resident 50's room revealed: *Resident 50 was sitting in his wheelchair with a urinary catheter (flexible tubing placed in the bladder to drain urine) bag that hung on the side of his wheelchair. *CNAs BB and CC stated they were going to transfer the resident to his bed and then to his recliner. *CNA CC did not wash her hands, and put on a gown and gloves. *CNA BB washed her hands and put on a gown and gloves. *CNAs BB and CC transferred Resident 50 to his bed using a total body lift. *CNAs BB and CC lowered resident 50's pants. CNA CC removed his incontinence brief, wiped his perineal area and buttocks with a wet cleaning wipe, and put barrier cream on resident 50's perineal (genital area) and buttocks. *With those same gloved hands, CNA CC assisted CNA BB to pull up resident 50's pants. *With those same gloved hands, CNA CC then adjusted his urinary catheter (flexible tubing placed in the bladder to drain urine) tubing and bag, transferred him to his recliner, held his hands during the transfer, placed his urinary catheter bag on the side of the recliner, covered him up with a blanket, moved a folding chair, and then took off her gown and gloves, discarded them, and washed her hands. *CNA BB left the residents room while wearing the same gown and gloves on, walked over to the (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	laundry room door, took off her gloves, did not wash her hands, grabbed keys to open the laundry room door, took off her gown, entered the laundry room, exited the laundry room, and then walked over to a sink in the kitchenette and washed her hands. Interview with CNA's BB and CC immediately after the observations above revealed resident 50 was on EBP because he had a catheter and an open skin wound. CNAs were to wash their hands before and after assisting residents with their care and when changing. CNA BB should have taken off her gown and gloves and washed her hands before leaving the resident's room. CNA CC should have removed her gloves, washed her hands, and put on a new pair of gloves after she put the barrier cream on the resident. Review of Resident 50's EMR (electronic medical record) revealed: *He was admitted on [DATE]. *He had a pressure ulcer (skin and/or underlying tissue injury from prolonged pressure) to his right ankle. *He had a urinary catheter. *His 12/25/25 care plan indicated he was on EBP because he had a feeding tube (a flexible tube that delivers liquid food and medicine directly to the stomach when unable to eat or drink by mouth). 6. Interview on 12/31/25 at 10:26 a.m. with CNA T revealed: *Each resident who used the sit-to-stand lift had their own sling. *If a sling became soiled it was to be sent to laundry to be cleaned. *The mechanical lifts were to be cleaned with disinfectant wipes between each resident use. *The disinfectant wipes were stored in a locked closet in the kitchenette. *She said when a resident was on EBP staff were to wear a gown and gloves when they assisted the resident to the toilet, changed their brief, or changed the resident's clothes. *She said gown did not need to be worn when transferring a resident on EBP. 7. Interview on 12/31/25 at 10:43 a.m. with licensed practical nurse (LPN) D revealed: *Hand hygiene was to be performed after using the toilet, after eating, before and after and resident cares, and before and after the use of gloves. *Residents on EBP were identified by the signage and the personal protective equipment on their door. *Residents would be on EBP if they had an infection or a urinary catheter. 8. Interview on 12/31/25 at 3:09 p.m. with director of nursing (DON) B revealed: *She expected hand hygiene to be completed anytime a staff member entered or exited a resident (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room, before and after providing resident contact care, and after assisting one resident, and before assisting another. *She expected staff to wear a gown and gloves when they provided direct care for residents on EBP, which included transferring residents in their rooms. *Each resident had their individual lift slings. *She expected the lifts to be cleaned between each use. *She verified not cleaning the lifts between resident and sharing lift slings could risk infections and allow for cross contamination between residents. *She stated when the sling strap was dragged on the floor, it was soiled and should have been sent to laundry, not used on another resident. 9. Review of the provider's 11/2025 LTC (long term care)- Hand Hygiene policy revealed: *Hand hygiene (HH) continues to be the primary means of preventing the transmission of infection. *HH, either with soap and water or with alcohol based hand rub (ABHR): 1. immediately before touching a resident 2. before a clean procedure or handling an invasive medical device 3. after contact with potential for body fluid or contaminated surfaces 4. after touching a resident or the resident's immediate environment 5. after removing gloves 10. Review of the provider's undated LTC - Transmission Based Precautions and Enhanced Barrier Precautions policy revealed: *Purpose: -To provide infection prevention and control recommendations for long-term-care. -Transmission of infectious organisms within a healthcare setting requires three elements to be linked: -A source (or reservoir) of infectious organisms -A susceptible host -A means of transmission for the organism. -Interruptions of this link in the chair of infection is achieved primarily by separating an individual (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	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physically (Transmission Based Precautions) or using a barrier (Enhanced Barrier Precautions). *[Provider] will incorporate the use of Standard Precautions, Enhanced Barrier Precautions, and additional Transmission Based Precautions as indicated for known, suspected or incubating infections or communicable diseases, and for the protection of residents, visitors, and staff from potential exposure to communicable and transmissible diseases. *Enhanced Barrier Precautions are used during high contact resident care activities for the following residents: Infection or colonization with an MDRO when contract precautions do not otherwise apply Wound requiring a dressing, regardless of MDRO status (e.g. central line, urinary catheter, feeding tube, trach) If a, b, or c: gown and gloves to be worn during high contact resident care activities, including (but not limited to) i. dressing ii. Bathing or showering iii. Transferring iv. Providing hygiene v. changing linen vi. Device care or use (Central lines, urinary catheter, feeding tube, trach adjustment/care) viii. Wound care (any wound requiring a dressing) *Staff is responsible for complying with precautions and for tactfully calling observed infractions to the attention of offenders. *In addition to what is posted on precautions signage, follow Standard Precautions by type of exposure anticipated and with additional tasks: a. Work from 'clean to dirty' b. Limit opportunities for 'touch contamination'-protect yourself, others, and the environment. If contamination occurs, remove PPE [personal protective equipment], complete hand hygiene and don clean PPE c. Do not touch your face or adjust PPE with contaminated gloves d. Do not touch environmental surfaces (including privacy curtains) except as necessary during resident care *Remove PPE appropriately and complete hand hygiene before leaving the room

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. **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 (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	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	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 provide staff with accurate information in the event of cardiac and/ or respiratory arrest.* e. A ?Medical Emergency' [a health condition or situation that needs immediate medical attention] is initiated on any resident needing emergency resuscitation due to a cardiac and/ or respiratory arrest unless there is a ?Do Not Resuscitate' order documented in the resident's electronic medical record. 10. Review of the provider's [DATE] Advance Directive policy revealed:* It is the policy of this facility will provide basic life support, including CPR - Cardiopulmonary Resuscitation, when a resident requires such emergency care, prior to the arrival of emergency medical services, subject to physician order and resident choice indicated in the resident's advance directives. Nurses are educated to initiate CPR, as recommended by the American Heart Association (AHA) unless: A valid Do Not Resuscitate order is in place.