STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN DIAL MANOR	410 SECOND STREET BRISTOL, SD 57219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/28/24 through 10/29/24. Areas surveyed included a resident accident with injury and restraint assessments related to the use of a lift chair. Sun Dial Manor was found not in compliance with the following requirements: F604 and F689.	F 000		
F 604 SS=E	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is	F 604	Administrator, DON, and interdisciplinary team in collaboration with the medical director to review, revise, create as necessary policy and procedure about ensuring assessment for safety and understanding lift chair operation is conducted and documented for the individual(s).Those deemed unsafe for independent operation should have care plan reflective of how and by whom lift chair will be operated safely. All should have care plan that reflects the use of the lift chair whether independent or assisted use. Provide education and training for all staff about their role and responsibility ensuring resident(s) safe use of a lift recliner chair, specialty wheel-chair, and other assistive devices. Staff responsible for safe lift recliner chair, specialty wheelchair, and other assistive devices operation will be re-educated on the updated policies and procedures to ensure safety and understanding lift recliner chair, specialty wheelchair, and other assistive device operation by the residents. Residents 1, 2, 3, 4, 5, and 6 will be reassessed to determine if their lift chair is a physical restraint and to ensure safe and understanding lift chair operation.	11-28-24

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

Joy Voss | Executive Director | 11-20-2024

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F 604	Continued From page 1 indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), SD DOH complaint intake report review, interview, observation, record review, and policy review, the provider failed to ensure: *Six of twelve severely cognitively impaired sampled residents (1, 2, 3, 4, 5, 6) who had lift recliner chairs in their rooms had been assessed for appropriate use and as potential restraints. * One of three severely cognitively impaired sampled residents (1) who used a specialty wheelchair had been assessed for the appropriate use to determine if it was a potential physical restraint. Findings include: 1. Review of the provider's FRI submitted on date/time revealed: *On 10/20/24 at 5:27 p.m. resident 1 was found on the floor in front of her lift recliner chair with the chair at its highest position. *She had a laceration to her left temple that required ambulance transport to the hospital for stitches. *The final report revealed that Minimum Data Set (MDS) coordinator/infection preventionist C educated nursing staff on the need to ensure that residents who were not cognitively intact cannot have access to their lift recliner chair remote. 2. The SD DOH complaint intake report review revealed concerns regarding: *Lack of safety assessment "prior to the use of	F 604	All other residents that use lift recliner chair, specialty wheelchair, and other assistive devices will be assessed to determine if device is a restraint and to ensure safe and understanding of operation. DON will audit assessments and care plans for lift recliner chair, specialty wheelchair, and other assistive devices once weekly for four weeks and monthly for two more months to ensure safe and understanding of lift recliner chair, specialty wheelchair, and other assistive device operations. MDS nurse will add assessment for lift recliner chair, specialty wheelchair, and other assistive devices to the resident quarterly MDS, or if there is a significant change. Care plan will be updated accordingly. DON will present audit findings at the monthly QAPI meetings for further review and consideration.	

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the lift chair."
*The residents "who are not cognitively intact cannot have access to their chair remotes" as "they are possibly restraining residents."

3. Interview on 10/29/24 at 9:04 a.m. with administrator A and director of nursing (DON) B revealed that they did not have a facility policy regarding the assessment of assistive devices to determine if their use would be a restraint.

4. Interview on 10/29/24 at 9:44 a.m. with MDS coordinator/infection preventionist C revealed:
*In response to resident 1's 10/20/24 fall from a lift recliner chair with injury, she stated that residents who are not cognitively intact should not have lift recliner chair remotes.
*She clarified that residents with severe cognitive impairment should not have lift recliner chair remotes.

5. Observation on 10/28/24 at 4:53 p.m. of resident 1 revealed:
*She was seated in her lift recliner chair with the leg rest in the up position.
*The chair remote was draped over the arm of the chair and was lying on the floor.
*She had a bruise on her left upper temple.

6. Review of resident 1's electronic medical record (EMR) revealed:
*Her 8/19/24 Brief Interview for Mental Status (BIMS) assessment score was 3 which indicated she had severe cognitive impairment.
*No assistive device assessment had been completed to determine if her lift recliner chair would be considered a restraint.

7. Observation on 10/29/24 at 10:50 a.m. of

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resident 2's room revealed a lift recliner chair was plugged in with the chair remote in the side pocket of the chair.

8. Review of resident 2's EMR revealed:
*Her 10/16/24 BIMS assessment score was 7 which indicated she had severe cognitive impairment.
*Her 5/14/24 MDS assessment indicated she was able to stand from a sitting position independently and was able to move from chair to chair independently.
*No assistive device assessment had been completed to determine if her lift recliner chair would be considered a restraint.

9. Interview on 10/29/24 at 10:54 a.m. with certified nursing assistant (CNA)/certified medication aide (CMA) D about resident 3 revealed:
*She had a lift recliner chair in her room.
*She was ambulatory and completed tasks independently.
*She was able to operate her chair remote appropriately.

10. Review of resident 3's EMR revealed:
*Her 9/10/24 BIMS assessment score was 3 which indicated she had severe cognitive impairment.
*No assistive device assessment had been completed to determine if her lift recliner chair would be considered a restraint.

11. Observation on 10/29/24 at 10:50 a.m. of resident 4's room revealed a lift recliner chair was plugged in with the chair remote on the right side draped over the arm of the chair.

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12. Review of resident 4's EMR revealed:
*His 9/3/24 MDS indicated his cognitive skill for daily decision-making was severely impaired.
*No assistive device assessment had been completed to determine if his lift recliner chair would be considered a restraint.

13. Observation on 10/29/24 at 10:50 a.m. of resident 5's room revealed a lift recliner chair was plugged in with the chair remote inside the left armrest.

14. Review of resident 5's EMR revealed:
*Her 9/6/24 BIMS assessment score was 5 which indicated she had severe cognitive impairment.
*No assistive device assessment had been completed to determine if her lift recliner chair would be considered a restraint.

15. Observation on 10/29/24 at 10:50 a.m. of resident 6's room revealed a lift recliner chair was plugged in with chair remote inside the right chair arm.

16. Interview on 10/29/24 at 11:22 a.m. with CNA E revealed resident 6 was not able to use the chair remote due to his dementia.

17. Review of resident 6's EMR revealed:
*His 9/23/24 MDS indicated his cognitive skill for daily decision-making was severely impaired.
*No assistive device assessment had been completed to determine if his lift recliner chair would be considered a restraint.

18. Observation on 10/29/24 at 8:25 a.m. of resident 1 revealed she was in the dining room seated in a specialty wheelchair.

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19. Interview on 10/29/24 at 9:04 a.m. with administrator A and DON B revealed they had no policy regarding assessing specialty wheelchairs as potential restraints.

20. Interview on 10/29/24 at 12:09 p.m. with MDS coordinator/infection preventionist C revealed:
*Three residents (1, 6, 7) were currently using Rock-King X3000 specialty wheelchairs.
-Resident 6 was assessed by occupational therapy (OT) for appropriate use of the specialty wheelchair on 2/12/24.
-Resident 7 was assessed by OT for appropriate use of the specialty wheelchair on 1/3/24.
*There was no assessment or evaluation completed for resident 1's use of the specialty wheelchair.

21. Review of the provider's October 2021 abuse and neglect policy revealed:
*"[Provider's name] shall ensure that the resident's environment remains as free of accident hazards as possible and that each resident received adequate supervision and assistive devices to prevent accidents."
*"Accident Hazards are defined as physical features in the facility environment which can endanger a resident's safety, including but not limited to: ...physical restraints."
*"[Provider's name] shall take ongoing steps to identify each resident at risk for accidents and/or falls, and adequately plan care, and implement procedures to prevent accidents, and shall assure that all residents receive a preliminary evaluation with physician's orders for immediate care, which shall be [completed] upon admission. In addition, residents shall receive a complete, comprehensive, accurate, and reproducible assessment of their functional capacity and the

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F 604	Continued From page 6 degree of accident risks to which each resident's condition places them. This assessment shall be standardized within the facility..."	F 604		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, and record review, the provider failed to ensure the safety of one of one sampled resident (1) who fell out of an electric lift chair and received a laceration to her left temple that required sutures. Findings include: 1. Review of the provider's 10/21/24 SD DOH FRI regarding resident 1 revealed: *On 10/20/24 at 5:27 p.m. she was found by certified nursing assistant (CNA) F lying on the floor of her room in front of her electric lift chair that was in the highest position with blood surrounding her head. *CNA F called for the nurse, Minimum Data Set (MDS) coordinator/infection preventionist C. *MDS coordinator/infection preventionist C assessed resident 1 and, after contacting the on-call provider and resident 1's daughter, sent resident 1 by ambulance to the nearby hospital's	F 689	Administrator, DON, and interdisciplinary team in collaboration with the medical director to review, revise, create as necessary policy and procedure about ensuring assessment for safety and understanding lift chair operation is conducted and documented for the individual(s).Those deemed unsafe for independent operation should have care plan reflective of how and by whom lift chair will be operated safely. All should have care plan that reflects the use of the lift chair whether independent or assisted use. Provide education and training for all staff about their role and responsibility ensuring resident(s) safe use of a lift recliner chair, specialty wheel-chair, and other assistive devices. Staff responsible for safe lift recliner chair, specialty wheelchair, and other assistive devices operation will be re-educated on the updated policies and procedures to ensure safety and understanding lift recliner chair, specialty wheelchair, and other assistive device operation by the residents. Resident 1 and other identified residents will be reassessed to determine if their electric lift chair and other assistive devices is a physical restraint and to en-sure safe and understanding operation. DON will audit assessments and care plans for electric lift chair and other assistive devices once weekly for four weeks and monthly for two more months to ensure safe and understanding of electric lift chair and other assistive device operations.	11-28-24

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F 689	Continued From page 7 emergency department (ED) due to the large laceration to her left temple. -Her LOC (Level of Cognition) and ROM (Range of Motion) were at her baseline. -Her vital signs were WNL (Within Normal Limits). *Resident 1 returned from the ED with sutures to her left temple and physician orders for: -Bacitracin antibiotic ointment to be applied to the left scalp laceration twice a day covered with a non-stick dressing. -Cephalexin (antibiotic) 500 mg (milligrams) by mouth three times daily for seven days. -Acetaminophen 325 mg as needed for pain for seven days, not to exceed five doses within 24 hours. *The provider determined resident 1 had fallen out of her electric lift chair after the attached chair control had raised the lift chair to the highest position. *Resident 1's cognition score was three, which indicated she had severe cognitive impairment. *After the incident, MDS coordinator/infection preventionist C "educated nursing staff on the need to ensure that residents who are not cognitively intact cannot have access to their chair remote [the attached chair control]." *Resident 1's "chair remote access was not care planned prior to the fall, but is now care planned to ensure she does not have access to her chair remote as she is at risk for falls." 2. Observation and interview on 10/28/24 at 4:53 p.m. with resident 1 in her room revealed: *She was in her electric lift chair with the legrest elevated. *Her upper left temple had a bruised area. -When asked about the bruise, she stated she had "bumped her head on the road." -She stated it had hurt, but it was not hurting at	F 689	MDS nurse will add assessment for electric lift chair and other assistive devices to the resident quarterly MDS, or if there is a significant change. Care plan will be updated accordingly. DON will present audit findings at the monthly QAPI meetings for further review and consideration.	

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the present time.
*She had a push pad call light on top of the blanket that was covering her legs.
*The attached chair control was over the right side of the chair's armrest and lying on the floor.

3. Interview on 10/29/24 at 9:04 a.m. with administrator A and director of nursing (DON) B revealed:
*DON B had worked at the facility for the past six years and had accepted the DON position six weeks ago.
*They had no policy regarding:
-The use of electric lift chairs.
-Safety assessments for the use of assistive devices including the electric lift chairs.
*DON B stated she did not have the staff assess a resident's ability to use the lift chair's remote control prior to use.
*The provider's electronic medical record system's "Assistive Device Assessment" was reviewed with DON B and she agreed the assessment would be useful to determine if a lift chair would be appropriate for use by a resident.

4. Interview on 10/29/24 at 9:44 a.m. with DON B and MDS coordinator/infection preventionist C revealed:
*MDS coordinator/infection preventionist C had been working at the facility for one month.
*They both agreed they did not have policies for the use of electric lift chairs and the assessment process for individual residents' use of those assistive devices.
*DON B stated there were multiple policies and procedures that needed to be updated.

Further interview with MDS coordinator/infection preventionist C revealed:

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*She had been working at the facility on Sunday, 10/20/24 when resident 1's fall incident occurred.
-Resident 1's injury was a "really deep skin tear, and I could not re-approximate the wound edges as they were irregular."
-She knew "right away" that resident 1's injury was a major injury.
-She had followed the 24-hour timeline in reporting incidents to the SD DOH.
-She made the FRI report to the SD DOH the next day, Monday 10/21/24 as there was no suspicion of abuse or neglect.

5. Review of resident 1's electronic medical record (EMR) revealed:
*She was admitted to the facility on 11/27/23.
*She had a principal diagnosis of Alzheimer's disease.
*Her 8/19/24 Brief Interview for Mental Status (BIMS) assessment score was three which indicated she had severe cognitive impairment.
*Her current care plan, printed on 10/28/24 revealed:
-A need area that indicated "I have an ADL [Activities of Daily Living] self-care performance deficit related to dementia."
-Interventions included:
--"TRANSFER: I am totally dependent on nursing staff for transferring."
-A need area that indicated "I am at high risk for falls related to Alzheimer's cognitive deficits" initiated on 11/29/23.
-Interventions included:
--"Anticipate and meet my needs."
--"Be sure my call light is within reach and encourage me to use it for assistance as needed. I require prompt response to all my requests for assistance."
--"Ensure that I do not have access to my recliner

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F 689	Continued From page 10 remote" had been added on 10/21/24. 6. A request was made on 10/28/24 at 7:10 p.m. from administrator A for the provider's policy regarding: *The use of electric lift chairs. *Safety assessments for the use of assistive devices including the electric lift chairs. The requested policies were not received by the end of the survey on 10/29/24 at 3:30 p.m.	F 689		