	-	ID HUMAN SERVICES			FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NC	D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
		435093	B. WING	^{NG} 10		
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SUN DIAL			4	10 SECOND STREET		
SON DIAL	MANON		В	RISTOL, SD 57219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	CFR Part 483, Subpa Term Care facilities w through 10/29/24. Are resident accident with assessments related	to the use of a lift chair. Sun I not in compliance with the				
F 604 SS=E	Right to be Free from CFR(s): 483.10(e)(1). §483.10(e) Respect a The resident has a rig and dignity, including §483.10(e)(1) The rig physical or chemical in purposes of discipline required to treat the ri- consistent with §483. §483.12 The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's mi- §483.12(a) The facilit §483.12(a)(2) Ensure from physical or chem purposes of discipline	Physical Restraints , 483.12(a)(2) and Dignity. ght to be treated with respect : th to be free from any restraints imposed for e or convenience, and not esident's medical symptoms, 12(a)(2). right to be free from abuse, tion of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- that the resident is free nical restraints imposed for e or convenience and that eat the resident's medical	F 604	Administrator, DON, and interdiscip team in collaboration with the medi director to review, revise, create as necessary policy and procedure at ensuring assessment for safety and understanding lift chair operation is conducted and documented for the individual(s). Those deemed unsafe independent operation should have plan reflective of how and by whom lift chair will be operated safely. All should have care plan that reflects of the lift chair whether independer or assisted use. Provide education training for all staff about their role responsibility ensuring resident(s) suse of a lift recliner chair, specialty chair, and other assistive devices. Staff responsible for safe lift recliner specialty wheelchair, and other assis devices operation will be re-educat the updated policies and procedure ensure safety and understanding li recliner chair, specialty wheelchair other assistive device operation by residents. Residents 1, 2, 3, 4, 5, and 6 will b reassessed to determine if their lift is a physical restraint and to ensure and understanding lift chair operation	cal cout d cout d cout d cout d cout cout cout cout cout cout cout cout	11-28-24
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
				Executive Director		11-20-2024

Joy Voss

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.

PRINTED: 11/13/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 435093 B. WING 10/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 410 SECOND STREET SUN DIAL MANOR BRISTOL, SD 57219 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 604 Continued From page 1 F 604 All other residents that use lift recliner chair, specialty wheelchair, and other indicated, the facility must use the least restrictive assistive devices will be assessed to alternative for the least amount of time and determine if device is a restraint and to document ongoing re-evaluation of the need for ensure safe and understanding of restraints. operation. This REQUIREMENT is not met as evidenced DON will audit assessments and care bv: plans for lift recliner chair, specialty Based on South Dakota Department of Health wheelchair, and other assistive devices (SD DOH) facility-reported incident (FRI), SD once weekly for four weeks and monthly DOH complaint intake report review, interview, for two more months to ensure safe and observation, record review, and policy review, the understanding of lift recliner chair, provider failed to ensure: specialty wheelchair, and other assistive device operations. MDS nurse will add *Six of twelve severely cognitively impaired sampled residents (1, 2, 3, 4, 5, 6) who had lift assessment for lift recliner chair, specialty wheelchair, and other assistive recliner chairs in their rooms had been assessed devices to the resident quarterly MDS, or for appropriate use and as potential restraints. if there is a significant change. Care plan * One of three severely cognitively impaired will be updated accordingly. sampled residents (1) who used a specialty wheelchair had been assessed for the DON will present audit findings at the appropriate use to determine if it was a potential monthly QAPI meetings for further review physical restraint. and consideration. 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

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 11/13/2024

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/13/2024 APPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		435093	B. WING		_	C 10/29/2024		
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
SUN DIAL	MANOR			110 SECOND STREET BRISTOL, SD 57219				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 604	cannot have access to "they are possibly res 3. Interview on 10/29/ administrator A and di revealed that they did regarding the assess determine if their use 4. Interview on 10/29/ coordinator/infection p *In response to reside lift recliner chair with i residents who are not have lift recliner chair *She clarified that res impairment should no remotes. 5. Observation on 10/ resident 1 revealed: *She was seated in he leg rest in the up posi *The chair remote wa the chair and was lyin *She had a bruise on 6. Review of resident record (EMR) reveale *Her 8/19/24 Brief Inte (BIMS) assessment s she had severe cogni *No assistive device a completed to determin would be considered a	are not cognitively intact o their chair remotes" as training residents." 24 at 9:04 a.m. with irector of nursing (DON) B not have a facility policy ment of assistive devices to would be a restraint. 24 at 9:44 a.m. with MDS preventionist C revealed: ent 1's 10/20/24 fall from a injury, she stated that cognitively intact should not remotes. idents with severe cognitive t have lift recliner chair 28/24 at 4:53 p.m. of er lift recliner chair with the tion. s draped over the arm of ig on the floor. her left upper temple. 1's electronic medical d: erview for Mental Status core was 3 which indicated tive impairment. assessment had been he if her lift recliner chair	F 604					

Facility ID: 0084

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CENTER	-	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		FORM	D: 11/13/2024 APPROVED 0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /			COMPLETED	
		435093	B. WING		_	C 10/29/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, 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	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	 plugged in with the chipocket of the chair. 8. Review of resident *Her 10/16/24 BIMS at which indicated she himpairment. *Her 5/14/24 MDS as able to stand from a stand was able to move independently. *No assistive device at completed to determine would be considered 9. Interview on 10/29/certified nursing assist medication aide (CMA revealed: *She had a lift recline *She was ambulatory independently. *She was able to ope appropriately. 10. Review of resident *Her 9/10/24 BIMS as which indicated she himpairment. *No assistive device at completed to determine would be considered 	 aaled a lift recliner chair was hair remote in the side 2's EMR revealed: assessment score was 7 ad severe cognitive sessment indicated she was itting position independently of from chair to chair assessment had been he if her lift recliner chair a restraint. 24 at 10:54 a.m. with tant (CNA)/certified A) D about resident 3 r chair in her room. and completed tasks rate her chair remote t 3's EMR revealed: sessment score was 3 ad severe cognitive assessment had been he if her lift recliner chair a restraint. 224 at 10:50 a.m. of ealed a lift recliner chair was hair remote on the right side 	F 60	4			

Facility ID: 0084

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/13/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435093	B. WING		_		C 29/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SUN DIAL	MANOR			10 SECOND STREET BRISTOL, SD 57219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	 daily decision-making *No assistive device a completed to determine would be considered a 13. Observation on 10 resident 5's room reverse plugged in with the charmrest. 14. Review of resident *Her 9/6/24 BIMS assistive device a completed to determine would be considered a 15. Observation on 10 resident 6's room reverse plugged in with chair to arm. 16. Interview on 10/29 E revealed resident 6 chair remote due to h 17. Review of resident 6 chair remote due to h 17. Review of resident 6 chair remote due to h 18. Observation on 10 	t 4's EMR revealed: cated his cognitive skill for was severely impaired. assessment had been he if his lift recliner chair a restraint. 0/29/24 at 10:50 a.m. of caled a lift recliner chair was hair remote inside the left t 5's EMR revealed: cessment score was 5 which vere cognitive impairment. assessment had been he if her lift recliner chair a restraint. 0/29/24 at 10:50 a.m. of caled a lift recliner chair was remote inside the right chair 0/24 at 11:22 a.m. with CNA was not able to use the is dementia. t 6's EMR revealed: icated his cognitive skill for was severely impaired. assessment had been he if his lift recliner chair a restraint. 0/29/24 at 8:25 a.m. of he was in the dining room	F 604				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/13/2024 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		435093	B. WING		_	(10/2	; 29/2024
NAME OF P	ROVIDER OR SUPPLIER		· [:	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
				410 SECOND STREET			
SUN DIAL	MANOR			BRISTOL, SD 57219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604	 policy regarding asse as potential restraints 20. Interview on 10/29 coordinator/infection p *Three residents (1, 6 Rock-King X3000 spe -Resident 6 was asset therapy (OT) for approvide the special ty w *There was no assessed the special ty w *There was no assessed the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *There was no assessed to the special ty w *"Accident Hazards as p resident received ade assistive devices to p *"Accident Hazards a features in the facility endanger a resident special to the spec	9/24 at 9:04 a.m. with ON B revealed they had no ssing specialty wheelchairs 9/24 at 12:09 p.m. with MDS preventionist C revealed: 6, 7) were currently using ecialty wheelchairs. ssed by occupational opriate use of the specialty 4. sseed by OT for appropriate heelchair on 1/3/24. sment or evaluation at 1's use of the specialty worker's October 2021 abuse realed: nall ensure that the fit remains as free of possible and that each quate supervision and revent accidents." re defined as physical environment which can as safety, including but not restraints." nall take ongoing steps to at risk for accidents and/or plan care, and implement t accidents, and shall assure ive a preliminary evaluation s for immediate care, which upon admission. In addition,	F 604				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. DOILDING			5
		435093	B. WING	10/29/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SUN DIAL	MANOR			410 SECOND STREET		
SON DIAL	MANOR			BRISTOL, SD 57219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 604			F 604	1		
		sks to which each resident's n. This assessment shall be ne facility"				
F 689 SS=G	Free of Accident Haza CFR(s): 483.25(d)(1)(§483.25(d) Accidents The facility must ensu §483.25(d)(1) The res as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on South Dak (SD DOH) facility-rep observation, interview provider failed to ensu sampled resident (1) chair and received a I that required sutures. Findings include:	ards/Supervision/Devices (2)	F 689	Administrator, DON, and interdisci team in collaboration with the med director to review, revise, create as necessary policy and procedure al ensuring assessment for safety an understanding lift chair operation is conducted and documented for the individual(s). Those deemed unsafi independent operation should hav plan reflective of how and by whor lift chair will be operated safely. Al should have care plan that reflects of the lift chair whether independen or assisted use. Provide education training for all staff about their role responsibility ensuring resident(s) use of a lift recliner chair, specialty chair, and other assistive devices.Staff responsible for safe lift recliner specialty wheelchair, and other as devices operation will be re-educa the updated policies and procedur ensure safety and understanding I recliner chair, specialty wheelchair other assistive device operation by residents.	ical sout d sout d se e for e care n the use nt and and safe wheel- er chair, sistive ted on es to ift , and	11-28-2
	*On 10/20/24 at 5:27 certified nursing assis floor of her room in fro that was in the highes surrounding her head *CNA F called for the (MDS) coordinator/inf *MDS coordinator/inf assessed resident 1 a on-call provider and r	p.m. she was found by stant (CNA) F lying on the ont of her electric lift chair st position with blood l. nurse, Minimum Data Set fection preventionist C.		Resident 1 and other identified res will be reassessed to determine if electric lift chair and other assistive devices is a physical restraint and sure safe and understanding opera DON will audit assessments and c for electric lift chair and other assist devices once weekly for four week monthly for two more months to er safe and understanding of electric and other assistive device operation	their to en- ation. are plans stive s and isure lift chair	

Facility ID: 0084

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/13/2024 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435093	B. WING			_	(10/	C 29/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	10/	20/2024
				41	0 SECOND STREET			
SUN DIAL	MANOR			в	RISTOL, SD 57219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 689	laceration to her left te -Her LOC (Level of Co of Motion) were at her -Her vital signs were V *Resident 1 returned the her left temple and ph -Bacitracin antibiotic co left scalp laceration tw non-stick dressing. -Cephalexin (antibiotic mouth three times dai -Acetaminophen 325 seven days, not to exc hours. *The provider determined out of her electric lift co control had raised the position. *Resident 1's cognition indicated she had sevent *After the incident, MID preventionist C "educe need to ensure that re- cognitively intact came chair remote [the attack *Resident 1's "chair re- planned prior to the fat to ensure she does not remote as she is at rise 2. Observation and im p.m. with resident 1 im *She was in her elector elevated. *Her upper left temple -When asked about the had "bumped her head	nt (ED) due to the large emple. ognition) and ROM (Range baseline. WNL (Within Normal Limits). from the ED with sutures to oysician orders for: bintment to be applied to the vice a day covered with a c) 500 mg (milligrams) by ly for seven days. mg as needed for pain for ceed five doses within 24 ned resident 1 had fallen chair after the attached chair lift chair to the highest n score was three, which rere cognitive impairment. DS coordinator/infection ated nursing staff on the esidents who are not not have access to their ched chair control]." emote access was not care all, but is now care planned of have access to her chair sk for falls." terview on 10/28/24 at 4:53 n her room revealed: ric lift chair with the legrest e had a bruised area. ne bruise, she stated she	F	689	MDS nurse will a electric lift chair a devices to the res if there is a signifi will be updated a DON will present monthly QAPI me and consideration	and other assistive sident quarterly M icant change. Car ccordingly. audit findings at t eetings for further	e DS, or e plan he	

Facility ID: 0084

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/13/2024 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		435093	B. WING		_	C 10/29/2024	
NAME OF PI	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SUN DIAL	MANOR			10 SECOND STREET BRISTOL, SD 57219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	side of the chair's arm 3. Interview on 10/29/ administrator A and di revealed: *DON B had worked a years and had accept weeks ago. *They had no policy m -The use of electric lif -Safety assessments devices including the *DON B stated she di a resident's ability to a control prior to use. *The provider's electr system's "Assistive D reviewed with DON B assessment would be chair would be approp 4. Interview on 10/29/ and MDS coordinator/ revealed: *MDS coordinator/ revealed: *They both agreed the the use of electric lift process for individual assistive devices. *DON B stated there procedures that need	call light on top of the ring her legs. ontrol was over the right mest and lying on the floor. 24 at 9:04 a.m. with irector of nursing (DON) B at the facility for the past six ted the DON position six egarding: t chairs. for the use of assistive electric lift chairs. d not have the staff assess use the lift chair's remote onic medical record evice Assessment" was and she agreed the e useful to determine if a lift oriate for use by a resident. 24 at 9:44 a.m. with DON B /infection preventionist C ection preventionist C had acility for one month. ey did not have policies for chairs and the assessment residents' use of those were multiple policies and ed to be updated. MDS coordinator/infection	F 689				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED MAD PLAN OF CORRECTION 435093 B. WING 10/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/29/2024 SUN DIAL MANOR SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 11/13/2024 MAPPROVED O. 0938-0391	
10/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21P CODE COLSPAN="2">PROVIDER OF ADDRESS OPENDER PROVIDER OF ADDRESS MADE OF PROVIDERS PROVIDER OF ADDRESS MADE OF PROVIDERS ADDRESS ADD	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY COMPLETED	
IMMAE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SUN DIAL MANOR INTEGET ADDRESS, CITY, STATE, ZIP CODE Image: Continued From page 9 Integet and for the control of DEFICIENCIES PREFIX Integet and for the control of DEFICIENCIES Image: Continued From page 9 Integet and for the control of t			435093	B. WING			10		
SUB DIAL MANOR BRISTOL, SD 57219 (M) ID PHEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CERTICKY MUST BE FACEODED BY FULL RECOLLATORY OR LSC UDENTIFYING INFORMATION) ID PAGE PHEFIX TAG PROVIDENTIFYING INFORMATION) ID PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION INFORMATION) ID PROVIDENTIFYING INFORMATION) ID PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING INFORMATION) ID PROVIDENTIFYING INFORMATION ID PROVIDENTIFYING	NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE			
PHRIP PREVIOUS DEFINITION PREVIOUS DEFINITION OPERATION MAID MEERIX TGG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MEST DE PRECEDED DE YULL) RECOLLORED THE APROPRIATE DEFICIENCY OF USCIDENTIFYING INFORMATION) Image: Deficiency MEST DEFICIENCY TAG PREVIOUS PRECEDED DEFICIENCY (EACH DEFICIENCY ALLORED APROPRIATE DEFICIENCY) OPERATION (EACH DEFICIENCY ALLORED APPROPRIATE DEFICIENCY) OPERATION (EACH DEFICIENCY ALLORED APPROPRIATE DEFICIENCY) OPERATION (EACH DEFICIENCY) F 688 Continued From page 9 "She had been working at the facility on Sunday, -Resident 1's injury was a "really deep skin tear, and I could not re-approximate the wound edges as they were irregular." -She karew '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. -She was admitted to the facility on 11/27/23. 'She had a principal diagnosis of Alzheimer's disease. ''Her Al'19/24 Brief Interview for Mental Status (BIMS) assessment score was three which indicated she had severe cognitive dipatiment. ''Her current care plan, printed on 10/28/24 revealed: -''Antoxisted to Alzheimer's disf for transferring.'' -''An eed area that indicated ''I have an ADL (Activites of Daily Living) self-care performance deficit related to Alzheimer's disf for transferring.'' -''An eed area that indicated ''I an at high risk for falls related to Alzheimer's: constructions included: -'''Antoigate and meet my meeds.''' -'''Be sure my call light is within reach and ''''''''''''''''''''''''''''''''''''					410 SECOND ST	REET			
Precipy TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Prefix TAG C(EACH ORRECTVE ACTION BAOULD BE CROSSREPERENCE) COMMENTE DEFICIENCY) F 689 Continued From page 9 F 689	SUN DIAL	MANOR			BRISTOL, SD	57219			
 *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 was admitted to the facility on 11/27/23. *She was admitted to the facility on 11/27/24. *She was admitted to the facility 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: -"Antecipate and meet my needs." -"Anticipate and meet my needs." 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EAC	CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPR	ULD BE	COMPLETION	
I require prompt response to all my requests for assistance." "Ensure that I do not have access to my recliner	F 689	*She had been workin 10/20/24 when reside -Resident 1's injury w and I could not re-app as they were irregular -She knew "right away was a major injury. -She had followed the reporting incidents to -She made the FRI re next day, Monday 10/ suspicion of abuse or 5. Review of resident record (EMR) reveale *She was admitted to *She had a principal of disease. *Her 8/19/24 Brief Inte (BIMS) assessment s indicated she had sew *Her current care plan revealed: -A need area that indi [Activities of Daily Livid deficit related to deme -Interventions include "TRANSFER: I am to staff for transferring." -A need area that indi falls related to Alzhein initiated on 11/29/23. -Interventions include "Anticipate and mee "Be sure my call ligh encourage me to use I require prompt respont assistance."	ng at the facility on Sunday, nt 1's fall incident occurred. as a "really deep skin tear, proximate the wound edges ." y" that resident 1's injury e 24-hour timeline in the SD DOH. port to the SD DOH the 21/24 as there was no neglect. 1's electronic medical d: the facility on 11/27/23. diagnosis of Alzheimer's erview for Mental Status core was three which vere cognitive impairment. n, printed on 10/28/24 cated "I have an ADL ing] self-care performance entia." d: otally dependent on nursing cated "I am at high risk for ner's cognitive deficits" d: t my needs." nt is within reach and it for assistance as needed. onse to all my requests for	F 68	39				

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 11/13/202 FORM APPROVEI OMB NO. 0938-039	D	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		435093	B. WING		_	C 10/29/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		٦	
SUN DIAL	MANOR			410 SECOND STREET BRISTOL, SD 57219				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION	(X5)	-	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
F 689	Continued From page	<u>></u> 10	F 68	0				
	remote" had been ad		1 00					
	 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. 							

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