STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/4/26 through 8/6/26. Sun Dial Manor was found not in compliance with the following requirements: F582, F684, F847, F880, and F883.	F0000		
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, observation, record review, and policy review the provider failed to ensure the quality of care for one of one sampled resident (2) who had a physician's order to be straight catheterized (placing a flexible tube into the bladder to drain urine, then removing the tube) twice a day when that order was discontinued in the provider's electronic medical record (EMR) system by one of one registered nurse (RN) (D) on 7/9/26, which resulted in the resident not having his urine drained by straight catheterization for sixteen days. That failure potentially contributed to the resident's hospitalization for evaluation and treatment of diagnosed urosepsis (infection in the bloodstream from a urinary tract infection [UTI]). Findings include: 1. Interview on 8/4/26 at 11:49 a.m. with resident 2's family member revealed that resident 2 needed to have straight catheterization twice daily, in the	F0684	Unable to change the outcome of the deficient practice for resident #2. The facility has determined that all residents have the ability to be affected by this deficiency. Administrator, Asst Administrator, DON and interdisciplinary team in collaberation with medical director will review and revise the Physician Orders policy and procedures as necessary to ensure staff are aware and follow physician orders. DON or designee will provide education to RN D and all other nursing staff responsible for following through on physicians' orders, and regarding their roles for ensuring the safety and well-being of residents along with the importance of their mandatory role. DON began daily audit of resident #2 straight cath results on 8-12-26. This will continue daily for resident 2 for one month and weekly for two months. DON will audit physician orders for 2 residents weekly for two months. DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	9-3-26

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 reverse for further 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
Joy Voss	Administrator	8-31-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

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F0684 SS = G	Continued from page 1 morning and the night, because he had a stroke a few months ago, and resident 2 would not leave the foley catheter (a flexible tube placed into the bladder to drain urine) in place. Resident 2 was recently hospitalized due to a UTI and a clogged bile duct. Resident 2's family member thought his UTI was related to the nursing home discontinuing his straight catheterizations a few weeks before his hospitalization. She did not find out the nursing home had discontinued those until resident 2 was admitted to the hospital. Resident 2's physician had told the staff that his straight catheterizations could be discontinued if his urinary output was consistently less than 200 milliliters (mL) and stated that it was not. She spoke to administrator A, director of nursing (DON)/infection preventionist (IP) B, and social service designee (SSD) G after resident 2 was hospitalized because she was upset that his straight catheterizations were discontinued, and they told her that his straight catheterizations were discontinued because because his urinary output was consistently less than 200 mL. She also expressed concern that the nurse's would ask him if he wanted to have his straight catheterization done, and resident 2 would say no. She did not think the nurses should ask him, but tell him it was time to do it because he was confused, would say no, but would then be cooperative with the procedure. She did not think that his straight catheterizations were being completed on time. 2. Review of resident 2's EMR revealed he admitted to the facility on 3/24/26. His 7/9/26 Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. His diagnoses included cerebral infarction (stroke), bacteremia (bacteria in the blood) and retention of urine (when your body cannot empty urine all the way). Resident 2's July 2026 TAR indicated he had a 4/29/26 physician's order for PVR straight catheterizations twice a day, and if the PVRs were consistently less than 200 mL then the straight catheters could be discontinued. On 7/1/26 resident 2 refused the straight catheter in the morning, and at night it was completed with 600 mL of urine emptied. On 7/2/26 he refused the straight catheter in the morning and at night. On 7/3/26 he refused	F0684		

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F0684 SS = G	Continued from page 2 the straight catheter in the morning, and at night it was completed with 800 mL of urine emptied. On 7/4/26 he had the straight catheter completed in the morning with 450 mL of urine emptied, and at night he had 550 mL of urine emptied. On 7/5/26, he had the straight catheter completed in the morning with 150 mL of urine emptied, and at night he had 250 mL of urine emptied. On 7/6/26 he had the straight catheter completed in the morning with 150 mL of urine emptied, and at night he had 250 mL of urine emptied. On 7/7/26 he refused the straight catheter in the morning, and at night it was not documented as refused or completed. On 7/8/26 he refused the straight catheter in the morning, and at night it was completed with 150 mL of urine emptied. On 7/9/26 he refused the straight catheter in the morning, and then the straight catheter was discontinued. Resident 2's August 2026 TAR indicated he had a 8/2/26 physician's order for a straight catheter twice daily, in the morning and at bedtime related to urinary retention. A straight catheter was completed on 8/2/26 at bedtime with 200 mL of urine emptied. On 8/3/26, 450 mL of urine was emptied in the morning and 450 mL of urine was emptied at bedtime. On 8/5/26, 825 mL of urine was emptied at 4:30 p.m. Resident 2's 7/24/26 emergency room (ER) notes indicated he was admitted for urosepsis. His blood culture and urine cultures were positive for Klebsiella pneumoniae (a bacteria). Resident 2's 7/31/26 hospital discharge orders revealed he had orders for urinary straight catheters to be completed twice a day starting on 7/31/26. He had discharge orders for ciprofloxacin (an antibiotic) every twelve hours and flagyl (a antifungal) three times daily. His hospital notes indicated his diagnoses were urosepsis, questionable staph hominis (type of bacteria), transaminitis (a lab showing high liver enzymes), cholangiocarcinoma (a rare type of bile duct cancer), vascular dementia (a decline in thinking, memory, and behaviors skills caused by damaged blood vessels that reduce or block blood flow to the brain), and urinary retention. 3. Observation and interview on 8/5/26 at 4:30 p.m. in resident 2's room with registered nurse (RN) D revealed that resident 2 refused his straight catheterization twice that morning. Resident 2 was lying in bed on his left side, and he had two family	F0684		

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F0684 SS = G	Continued from page 3 members in his room. RN D knelt by resident 2's head, and asked him if she could do his straight catheterization. Resident 2 said "no". Resident 2's family member other said "yes, you can," and resident 2 did not say anything. Resident 2's family members exited the room, RN D collected her supplies, positioned resident 2 on his back, and performed the procedure. Resident 2 was cooperative during the procedure and RN D obtained 825 mL of tea colored urine. 4. Interview on 8/6/26 at 9:42 a.m. with resident 2's family member revealed that when resident 2 readmitted to the facility on 7/31/26, he had a physician's order from the hospital to have the straight catheterizations completed at the nursing home and said, "I made sure of that." On 8/5/26, she arrived at the nursing home between 10:30 a.m. and 11:00 a.m., and RN D did not tell her that resident 2 refused his straight catheterization that morning. RN D did not attempt to complete the straight catheterization until the surveyor and RN D came to his room at 4:30 p.m. 5. Interview on 8/6/26 at 10:06 a.m. with RN D revealed she discontinued resident 2's straight catheterization order in resident 2's EMR on 7/9/26 because she thought it was "a random thing" and did not need to be on his EMR treatment administration record (TAR). The order was to complete post void residuals (amount of urine left in the bladder after urinating), which were completed it by putting a catheter in his bladder after he urinated, and then measuring and recording how many mL's of urine was left in his bladder. Resident 2 did urinate some on his own. She acknowledged that not completing his straight catheterizations could have caused him to have a UTI. On 8/5/26 she attempted to complete resident 2's straight catheterization twice before 10:30 a.m. and he refused. It was her normal practice to call his family member if he refused twice. She did not call his family member that day, but intended to attempt his straight catheterization again when his family member planned on being there. RN D was busy and not able attempt the straight catheterization for resident 2 until the surveyor requested to observe the procedure. 6. On 8/6/26 at 10:59 a.m. DON/IP B stated they did not have a policy related to post void residual (PVR)	F0684		

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F0684 SS = G	Continued from page 4 (urine left in the bladder after urinating). 7. Interview and EMR review on 8/6/26 at 11:42 a.m. with administrator A and DON/IP B revealed that resident 2 was admitted to the hospital on 7/24/26 and readmitted to the nursing home on 7/31/26. On 7/27/26 they received a phone call from resident 2's family member and that was how they found out his straight catheterizations were discontinued. DON/IP B stated that his hospital paperwork indicated that he was hospitalized for issues related to his liver bile duct being clogged and not from a UTI. RN D discontinued resident 2's straight catheterization order and should not have. Resident 2 voided urine on his own at times. The 4/29/26 physician's order said if his PVR was consistently under 200 mL's after having a straight catheterization, the straight catheterizations could be discontinued. DON/IP B agreed his PVR was not consistently under 200 mL when RN D discontinued his straight catheterization order. Administrator A thought resident 2's PVR was consistently under 200 mL's and that was why that order was discontinued. DON/IP B had told resident 2's family that the straight catheterizations should not have been discontinued, and that she would ensure they were continued when resident 2 readmitted to the nursing home. Resident 2 readmitted to the nursing home on 7/31/26 and his straight catheterization physician's orders were not added to his TAR for nursing to complete until 8/2/26. DON/IP B agreed that his straight catheterizations should have been started on 7/31/26. DON/IP B said resident 2 sometimes refused his straight catheterizations sometimes. She did not expect the nurses to ask resident 2 if he wanted to the straight catheterizations completed. It should have been worded differently, such as "It is time." If he refused to have the straight catheterization, the nurses were expected to try again later or have a different staff member reapproach the resident about it. After resident 2 refused his straight catheterization the morning of 8/5/26, DON/IP B thought reattempting to complete the straight catheterization at 4:30 p.m. was acceptable. They agreed that resident 2 was a vulnerable adult and relied on the facility's staff for his care. 8. Review of the provider's 6/23/21 Physician	F0684		

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F0684 SS = G	Continued from page 5 Orders policy indicated that "when a new order is obtained from the provider, Nursing will ensure the order is carried through and followed correctly....and that the MAR/TAR is updated correctly."	F0684		
F0582 SS = E	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F0582	Unable to change the outcome of the deficient practice for residents 18, 28, and 30 for failure to ensure the proper Medicare notices were completed accurately. The Medicare notices were updated to accurately reflect the required formatting on 8-24-26. The Administrator will provide education to the Assistant Administrator and DON. The education will include the information provided on the form instructions. The facility has determined that all residents on Medicare/Medicaid have the ability to be affected by this deficiency. The Administrator or designee will audit Medicare notices for accuracy once per week for four weeks and monthly for two additional months. The Administrator or designee will present findings from audits at the monthly QAPI meeting and continue audits until the facility demonstrates sustained compliance as determined by the QAPI committee.	9-3-26

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F0582 SS = E	Continued from page 6 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the provider failed to ensure the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Centers for Medicare and Medicaid Services (CMS)-10055 Part A form and Notice of Medicare Non-Coverage (NOMNC) Form CMS-10123 was provided for three of three sampled residents (18, 28, and 30) instead, the facility provided the CMS-R-131 Part B form for outpatient services to two of three sampled residents (18, and 28) who's Medicare covered services were ending with remaining Medicare benefit days and remained in the facility and failed to give that notice 48 hours before those services ended for three of three sampled residents (18, 28, and 30). Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 8/4/26 revealed residents 18, 28, and 30 were identified as having discharged from Medicare Part A skilled services. Residents (18, and 28) remained in the facility following their discharge from Medicare Part A skilled services. Resident (30) was discharged against medical advice (AMA) following his discharge from Medicare Part A skilled services. 2. Review of resident 18's Skilled Nursing Facility Beneficiary Notification Review form revealed that resident 18's Medicare Part A Skilled Services Episode start date was 3/10/26. Resident 18's last covered day of Part A was 5/29/26. The form CMS-R-131 and CMS-10123 were received from administrator A and had been signed by the resident on 5/26/26. There was no documentation that indicated a SNF Advance Beneficiary Notice Non-coverage (ABN) CMS-10055 form was explained, issued, or given to resident 18 for the end of the Medicare covered episode. 3. Review of resident 28's Skilled Nursing Facility Beneficiary Notification Review form for residents	F0582		

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F0582 SS = E	Continued from page 7 who received Medicare Part A services revealed that resident 28's Medicare Part A Skilled Services Episode start date was 5/18/26. Resident 18's last covered day of Part A was 6/1/26. The CMS-R-131 and CMS-10123 were received from administrator A and had been signed by the resident representative on 6/1/26. There was no documentation indicated a SNF Advance Beneficiary Notice Non-coverage (ABN) CMS-10055 form was explained, issued, or given to resident 28 for the end of the Medicare covered episode. 4. Review of resident 30's Skilled Nursing Facility Beneficiary Notification Review form for residents who received Medicare Part A services revealed that resident 30's Medicare Part A Skilled Services Episode start date was 2/12/26. Resident 30's last covered day of Part A was 3/29/26. He had a NOMNC Form CMS-10123 signed by the resident on 3/30/26. There was no documentation indicating the SNF Advance Beneficiary Notice Non-coverage (ABN) CMS-10055 form was explained, issued, or given to resident 30 for the end of the Medicare covered episode. He discharged against medical advice (AMA) on 3/30/26. 5. Interview on 8/6/26 at 8:21 a.m. with administrator A revealed she was responsible for completing the Medicare SNF benefit and NOMNC forms for the residents at the facility. She was aware that those notices needed to be given to residents or resident representatives 48 hours before the resident's last covered day of Medicare Part A Service. She agreed the notices were not given 48 hours before the last covered day of Part A Service. She was not aware the wrong form was used.	F0582	Type text here	
F0847 SS = E	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of	F0847	The paragraph pertaining to Arbitration was removed immediately from the facility Admission Agreement. New Admission Agreements without this information will be signed by resident/ resident representative for residents 2, 4, 8, 14, 18, 20, 21, and 24. The facility has determined that only residents 2, 4, 8, 14, 18, 20, 21, and 24 were affected by this deficiency due to the Arbitration information being added to the facility Admission Agreement on 2-19-26. Facility has made the decision to no longer use an Arbitration Agreement at this time.	9-3-26

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F0847 SS = E	Continued from page 8 admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview, and record review, the provider failed to ensure residents who entered into an Arbitration Agreement upon admission to the facility were explicitly granted the right to rescind the agreement within 30 calendar days of signing it for eight of eight sampled residents (2, 4, 8, 14, 18, 20, 21, and 24). The Arbitration Agreement did not indicate that the resident or the resident's representative was not required to sign the arbitration agreement as a condition of admission to or as a requirement to continue to receive care at the facility. Findings include:	F0847		

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F0847 SS = E	Continued from page 9 1. Interview on 8/6/26 at 8:36 a.m. with resident 18 in his room regarding the Arbitration agreement addendum he had signed upon admission to the revealed he did not remember signing the arbitration agreement. He did not remember if he was told he had 30 days to rescind the agreement, or that a third party would be used during the arbitration that was agreed upon by both parties. He stated, "I signed a lot of papers" when he admitted to the facility. 2. Review of resident 18's electronic medical record (EMR) revealed he admitted to the facility on 3/10/26. He had a Brief Interview for Mental Status (BIMS) assessment score of 11, which indicated his cognition was moderately impaired. He had signed his 3/10/26 admission agreement, and the admission packet included information regarding arbitration. 3. Interview on 8/6/26 at 9:15 a.m. with administrator A revealed the provider did not have an arbitration policy, only the information that was included in the resident's admission agreement. She thought the arbitration agreements started in February of 2026. 4. Interview on 8/6/26 at 11:18 a.m. with social service designee (SSD) G revealed she was responsible for completing the resident's admission paperwork when they were admitted to the facility. The arbitration agreements had started on 2/19/26 and eight of the current twenty-four residents had signed arbitration agreements. She agreed the current arbitration agreements that the residents and their representatives had signed did not include the required information. That information included that the resident or their representative had the right to rescind the agreement within 30 calendar days of signing the form, and that the resident or their representative was not required to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. 5. Interview on 8/6/26 at 11:23 a.m. with administrator A revealed the current arbitration agreements did not include the required information. That information included the resident or their representative had the right to rescind the agreement within 30 calendar days of signing the form, and that the resident or their representative was not required to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. She was not aware that the arbitration agreemen needed to have that required information in it. No one had used the arbitration process to settle a dispute. She had	F0847		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 57219**

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F0847 SS = E	Continued from page 10 received the current arbitration agreement from the managing company to add to their resident admission packet. 6. Review of the Arbitration section of the resident admission packet revealed, "With the exception of collection actions, Sun Dial Manor and Resident agree that any controversy or claim arising out of or relating to the Admission Agreement shall be settled by binding arbitration and that arbitration is the parties' exclusive dispute resolution mechanism. Non-collection disputes shall be resolved in accordance with the facility grievance process. Should litigation be necessary to enforce the arbitrators' decision, the prevailing party is entitled to recover all costs of collection or enforcement, including reasonable attorney's fees and costs. This Admission Agreement shall be governed by the laws of the State of South Dakota and the parties agree that jurisdiction for any court proceedings arising out of or relating to this Contract shall lie exclusively in the courts of Day County, South Dakota. Sun Dial Manor shall be entitled to collect its reasonable attorneys' fees and costs associated with any collection action or other litigation outside of arbitration."	F0847	Type text here	
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	Unable to change the outcome of the deficient practice for residents 2, 3, and 20. The facility has determined that all residents have the ability to be affected by this deficiency. The Administrator, Asst Administrator, DON and Housekeeping Supervisor will review and revise as necessary the Housekeeping and Pest Control and Handwashing policies and procedures. An all-staff meeting will be held on 9-1-26 to provide education on citation F880, review policies and procedures, and the requirements to ensure future compliance with the facility policies. The DON or designee will audit observation of sterile technique of the straight cath once per week for four weeks and monthly for two additional months. The Housekeeping Supervisor or designee will audit observation of wet times during room cleaning once per week for four weeks and monthly for two additional months. The DON or designee will present findings from audits at the monthly QAPI meeting and continue	

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F0880 SS = E	Continued from page 11 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, manufacturer's	F0880	audits until the facility demonstrates sustained compliance as determined by the QAPI committee.	9-3-26

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F0880 SS = E	Continued from page 12 directions for use review, and policy review, the provider failed to ensure the staff followed infection control practices for hand hygiene and glove use by one of one observed registered nurse (RN) (D) during one of one sampled resident's (2) straight catheterization (placing flexible tubing in the bladder to drain urine and then removing the tubing) procedure and for disinfectant use according to the manufacturer's directions by one of one observed housekeeping direction (E) while cleaning two of two sampled residents' (3 and 20) rooms. Findings include: 1. Observation on 8/5/26 at 8:23 a.m. of housekeeping director E in resident 20's room revealed she sprayed pH7Q Dual disinfectant cleaner on the door handles and immediately wiped the door handles with a dry towel. She repeated that same process for cleaning the bedside table, nightstand handles, and the television remote. She sprayed Rest Stop Restroom Disinfectant cleaner on the bathroom handrails and immediately wiped the bathroom handrails with a dry towel. She repeated that same process for cleaning the sink and the toilet. 2. Observation and interview on 8/5/26 beginning at 9:56 a.m. with housekeeping director E in resident 3's room revealed she sprayed pH7Q Dual disinfectant cleaner on door handles and immediately wiped the door handles with a dry towel. She repeated that same process for cleaning the light switch. She touched the door handle and the light switch she had just wiped and agreed it was dry. She agreed that for the disinfectant to be effective at killing germs, the surface sprayed was supposed to stay wet for 10 minutes. At 10:02 a.m. she sprayed resident 3's nightstand handles and then immediately wiped them with a dry towel. At 10:06 a.m. she sprayed Rest Stop Restroom Disinfectant on the handrails and immediately wiped the handrails with a dry towel. She repeated that same process for cleaning the sink and the toilet in the bathroom. 3. Interview on 8/5/26 at 11:14 a.m. with director of nursing (DON)/infection preventionist (IP) B revealed that she expected housekeeping director E to leave the surfaces sprayed with pH7Q Dual cleaner and Rest Stop Restroom Disinfectant cleaner wet for 10 minutes, otherwise the surfaces in the resident's	F0880		

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F0880 SS = E	Continued from page 13 rooms would not be disinfected. 4. Review of the manufacturer's pH7Q Dual disinfectant cleaner's directions for use sheet provided by the provider revealed, that for use as a medical disinfectant, "treated surfaces must remain wet for 10 minutes." "Allow to air dry." 5. Review of the manufacturer's Rest Stop Restroom Disinfectant directions for use sheet provided by the provider revealed, that for disinfecting surfaces, they "must remain wet for 10 minutes." 6. Review of the provider's June 2020 Housekeeping and Pest Control policy did not indicate a contact time for the chemicals used for cleaning a resident's room. 7. Observation on 8/5/26 at 4:30 p.m. of RN D in resident 2's room revealed she washed her hands, set up the straight catheter supplies on a bedside table, put on a pair of gloves, and positioned the resident for the straight catheterization procedure. She removed her gloves and discarded them in the trash can. She washed her hands, put on a pair of gloves, grabbed a soapy wet washcloth, performed perineal care (cleaning around the genital area), and dried the area with a towel. She put that used washcloth and towel on the floor next to the bed. She removed her gloves and threw them in the garbage can. Without washing her hands, she put on a pair of sterile gloves and performed the straight catheterization procedure. 8. Interview on 8/5/26 at 5:07 p.m. with DON/IP B revealed that she expected RN D to perform hand hygiene (hand washing) after completing perineal care and before putting on gloves to perform a straight catheterization procedure. 9. Review of the provider's October 2024 Handwashing policy revealed that hand washing was to be completed before doing an aseptic (a set of practices used to stop harmful germs from getting into a patient's body during medical care) technique such as inserting a catheter.	F0880		

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F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F0883	The facility has determined that all residents who choose to receive a vaccination have the ability to be affected by this deficiency. DON or designee will ensure the pneumococcal vaccines are up to date for residents 8 and 21. DON or designee will ensure that all documentation for the refusal of the pneumococcal vaccines for residents 2 and 14 are completed. DON will review and revise as necessary the Resident Vaccinations policy. DON or designee will educate all staff that are responsible for administering vaccination to ensure future compliance with the facility policies. DON or designee will audit all new admissions and 2026 vaccination pre-screenings when available (not yet scheduled) and DON or designee will present findings from these audits at the monthly QAPI committee for reviews until QAPI committee advises to discontinue monitoring.	9-3-26

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F0883 SS = E	Continued from page 15 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review the provider failed to ensure pneumococcal vaccinations were up to date for two of three sampled residents (8 and 21) and that the risks and benefits information of receiving the pneumococcal vaccines were documented as provided in the resident's electronic medical record (EMR) to two of two sampled residents (2 and 14) who refused pneumococcal vaccination. Findings include: 1. Review of resident 8's EMR revealed she admitted to the facility on 9/10/25. She received an unspecified formulation of the pneumococcal conjugate vaccine on 7/1/15, and the pneumococcal polysaccharide vaccine (PPV)23 on 7/6/16. According to the PnuemoRecs Vax Advisor App (resource for the Centers for Disease Control and Prevention's current adult vaccine recommendations), resident 8 needed one dose of either PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23 to have her pneumococcal vaccines up to date. 2. Review of resident 21's EMR revealed she admitted to the facility on 5/20/26. She received the pneumococcal conjugate vaccine (PCV)13 on 6/24/15. According to the PnuemoRecs Vax Advisor App, resident 21 needed one dose of either PCV20 or PCV21 at least 1 year after receiving the PCV13 vaccine to have her pneumococcal vaccines up to date. 3. Review of resident 2's EMR revealed he admitted to the facility on 3/24/26. He refused the pneumococcal vaccine on an unspecified date. There was no documentation to support that education regarding the risks and benefits of receiving the	F0883		

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F0883 SS = E	Continued from page 16 pneumococcal vaccine was provided to the resident 2 or his representative. 4. Review of resident 14's EMR revealed he admitted to the facility on 4/1/26. He refused the pneumococcal vaccine on an unspecified date. There was no documentation to support that education regarding the risks and benefits of receiving the pneumococcal vaccine was provided to the resident 14 or his representative. 5. Interview on 8/6/26 at 10:59 a.m. with director of nursing (DON)/infection preventionist (IP) B revealed she was responsible for the resident's vaccinations. She did not obtain documentation that resident 2, resident 14, or their representatives were educated regarding the risks and benefits of receiving the pneumococcal vaccine. 6. Review of the provider's July 2026 Resident Vaccinations policy revealed that the facility was to "offer educational materials and resources to the resident and/or the resident's legal representative on the benefits and safety of the vaccines upon request." 7. Review of the provider's July 2026 Vaccination Consent policy revealed that "the medical team will assess each resident's vaccination needs based on current health guidelines, individual medical history, and recommendations from health authorities." "Staff will provide residents and their authorized representatives with comprehensive information regarding: The specific vaccine(s) being offered.", "The benefits of vaccination.", "Potential risks and side effects associated with the vaccine.", Alternatives to vaccination (if applicable).", and "The importance of timely vaccination." "Upon receiving consent, staff will document: The date of consent.", "The name of the vaccine.", "The signature of the resident or authorized representative.", "Any pertinent discussions that took place during the informed consent process." "Documentation will be maintained in the resident's medical record."	F0883		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/5/26. Sun Dial Manor was found not in compliance with the following requirement(S): E039.	E0000		
E0039 SS = D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is	E0039	The full-scale Emergency Preparedness exercise that was scheduled for 8-4-26 and then cancelled due to State Surveyors arriving, has been re-scheduled for 9-1-26. The facility has determined that all residents and staff have the ability to be affected by this deficiency. An all-staff meeting will be held on 9-1-26 to provide education on citation E0039, review policies and procedures, and the requirements to ensure future compliance with the facility policies. An exercise was completed on 6-29-26 for a tornado warning; residents were moved to hallways, all curtains and doors closed. Preparation for evacuation, if needed. The Administrator or designee will be responsible for ensuring the Emergency Preparedness Testing requirements are completed annually, documented appropriately, and used to guide ongoing Emergency Preparedness practices. The Administrator or designee will verify completion of the annual EP Testing requirements and document the review for the next 23 months and continue audits annually until the facility demonstrates sustained compliance as determined by the QAPI committee.	9-3-26

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 reverse for further 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
Joy Voss	Administrator	8-26-26

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E0039 SS = D	Continued from page 1 conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E0039		

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E0039 SS = D	Continued from page 2 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:	E0039		

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(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
E0039 SS = D	Continued from page 3 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 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
E0039 SS = D	Continued from page 4 following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

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E0039 SS = D	Continued from page 5 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

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E0039 SS = D	Continued from page 6 emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0039 SS = D	Continued from page 7 workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to develop, establish, review, and maintain updated at least annually, a facility Emergency Preparedness training and testing program which included staff drills using emergency procedures in accordance with Section 483.73(d)(2). Findings include: 1. Record review on 8/5/26 at 2:32 p.m. revealed documentation was unable to be provided showing an annual full-scale Emergency Preparedness exercise was conducted during the past year. In addition, documentation was not available to show any tabletop exercise were conducted. In addition to a primary full-scale exercise a second full-scale or tabletop drill must be conducted to achieve the annual drill requirements.	E0039		

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	435093	A. BUILDING B. WING	08/05/2026

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E0039 SS = D	Continued from page 8 Interview with the administrator at that same time confirmed that finding. She stated they were in the process of improving their Emergency Preparedness Program. She further stated the facility cancelled a drill they had planned for the previous day (8/4/26) because the state survey team had arrived at the facility that morning. This deficient practice could affect all residents, as well as an undetermined number of staff and visitors in the event of an actual emergency event where the Emergency Preparedness Program is required to be utilized.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/5/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sun Dial Manor was found in compliance.	K0000		

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 reverse for further 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
Joy Voss	Administrator	8-26-26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10598	A. BUILDING: _____ B. WING _____	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN DIAL MANOR	410 2ND STREET POST OFFICE BOX 337 BRISTOL, SD 57219

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/4/26 through 8/6/26. Sun Dial Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Voss — TITLE: Administrator — (X6) DATE: 8-26-26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 8/5/26. Sun Dial Manor was found not in compliance with the following requirement(S): E039.	E0000		
E0039 SS = D	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is	E0039	The full-scale Emergency Preparedness exercise that was scheduled for 8-4-26 and then cancelled due to State Surveyors arriving, has been re-scheduled for 9-1-26. The facility has determined that all residents and staff have the ability to be affected by this deficienty. An all-staff meeting will be held on 9-1-26 to provide education on citation E0039, review policies and procedures, and the requirements to ensure future compliance with the facility policies. An exercise was completed on 6-29-26 for a tornado warning; residents were moved to hallways, all curtains and doors closed. Preparation for evacuation, if needed. The Administrator or designee will be responsible for ensuring the Emergency Preparedness Testing requirements are completed annually, documented appropriately, and used to guide ongoing Emergency Preparedness practices. The Administrator or designee will verify completion of the annual EP Testing requirements and document the review for the next 23 months and continue audits annually until the facility demonstrates sustained compliance as determined by the QAPI committee.	9-3-26

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E0039 SS = D	Continued from page 1 conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or	E0039		

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E0039 SS = D	Continued from page 2 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:	E0039		

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E0039 SS = D	Continued from page 3 (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise	E0039		

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E0039 SS = D	Continued from page 4 following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 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
E0039 SS = D	Continued from page 5 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's	E0039		

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Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 57219**

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E0039 SS = D	Continued from page 6 emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 57219**

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E0039 SS = D	Continued from page 7 workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to develop, establish, review, and maintain updated at least annually, a facility Emergency Preparedness training and testing program which included staff drills using emergency procedures in accordance with Section 483.73(d)(2). Findings include: 1. Record review on 8/5/26 at 2:32 p.m. revealed documentation was unable to be provided showing an annual full-scale Emergency Preparedness exercise was conducted during the past year. In addition, documentation was not available to show any tabletop exercise were conducted. In addition to a primary full-scale exercise a second full-scale or tabletop drill must be conducted to achieve the annual drill requirements.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E0039 SS = D	Continued from page 8 Interview with the administrator at that same time confirmed that finding. She stated they were in the process of improving their Emergency Preparedness Program. She further stated the facility cancelled a drill they had planned for the previous day (8/4/26) because the state survey team had arrived at the facility that morning. This deficient practice could affect all residents, as well as an undetermined number of staff and visitors in the event of an actual emergency event where the Emergency Preparedness Program is required to be utilized.	E0039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING **01 - MAIN BUILD...** B. WING	**08/05/2026**

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Sun Dial Manor	**410 SECOND STREET POST OFFICE BOX 337, BRISTOL, South Dakota, 57219**

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K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 8/5/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sun Dial Manor was found in compliance.	K0000		

ıny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other afeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 0 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 4 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 rogram participation.

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Joy Voss	Administrator	8-26-26

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10598	A. BUILDING: _____ B. WING _____	08/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUN DIAL MANOR	410 2ND STREET POST OFFICE BOX 337 BRISTOL, SD 57219

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/4/26 through 8/6/26. Sun Dial Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Voss — TITLE: Administrator — (X6) DATE: 8-26-26