STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 05/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/18/25 through 5/21/25. Sun Dial Manor was found not in compliance with the following requirements: F554, F582, F606, F641, F655, F700, F812, F813, F880, and F940. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 5/18/25 through 5/21/25. The areas surveyed included potential verbal abuse by a staff member to a resident and training topics for staff. Sun Dial Manor was found not in compliance with the following requirement: F940.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) observed self-administering a nebulizer (device that converts liquid medication into an inhaled mist) treatment in her room, was assessed for the ability to safely self-administer medications, and had a physician's order to self-administer medications according to the provider's policy. Findings include: 1. Observation and interview on 5/19/25 at 8:38	F 554	Resident #1 was assessed and found to have the ability to safely self-administer nebulizer treatments. A physician's order was then obtained for resident #1 stating that she may self-administer nebulizer treatments once set up by nursing staff. The care plan was updated accordingly. The executive director (ED) and director of nursing (DON) have reviewed and updated the Assessment Process for Self-Admin of Meds policy and procedures. All other residents' medications regimens were to reviewed to ensure that if a resident is self-administering their medications that the facility has a physician's order, resident is evaluated to determine if they are able to safely self-administer along with updated care plan. An all-staff meeting will be held on 6/24/25 to provide education on citation F554, policy and procedures, and the	7-5-25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Voss
TITLE: Executive Director
(X6) DATE: 6-20-25

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.

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F 554	Continued From page 1 a.m. with resident 1 in her room revealed: *A nebulizer machine with a disassembled nebulizer mask was on her bedside table. *She stated she administered nebulizer medication treatments multiple times per day. *Nursing staff would bring her the medication, set up the nebulizer administration of the medication, leave her room, and then she would administer the nebulizer treatment to herself. *She stated staff would return to her room after she finished administering the nebulizer treatment. They would rinse out the nebulizer mask and then place it on her bedside table to dry. Observation on 5/19/25 at 11:27 a.m. of resident 1 in her room revealed: *She was sitting alone in her room. *She had her nebulizer mask on her face, the nebulizer machine was running, and medication was being inhaled by resident 1 through the nebulizer mask. *No staff were present in resident 1's room or within an area that enabled staff to visualize her. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 3/8/23. *Her 3/14/25 Brief Interview of Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *She had a diagnosis of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and can make it difficult to breathe). *A 10/8/24 physician's order for "Ipratropium-Albuterol Inhalation Solution(medication to open airways in the lungs) 0.5-2.5 (3) MG [milligrams]/3ML [milliliters] (Ipratropium-Albuterol) 1 vial inhale orally via neb	F 554	the requirements to ensure future compliance with the facility policy. The facility has determined that all residents have the ability to be affected by this deficiency. DON or designee will audit once per week for four weeks and monthly for two additional months to ensure that any new self-administration requests and nebulizer administrations are assessed per the updated policy. DON 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.	

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F 554	Continued From page 2 [nebulizer] four times daily" and "every 4 hours as needed for Cough". *There was no physician's order for her to self-administer the nebulizer medication. *There was no self-administration of medication assessment completed. *Self-administration of medications was not included in resident 1's 5/19/25 care plan. 2. Interview on 5/20/25 at 4:19 p.m. with Minimum Data Set (MDS) coordinator/infection preventionist C revealed: *She completed the resident assessments quarterly with her MDS submissions, which would include an assessment for self-administration of medications. *She was not aware of any resident at the facility who self-administered medications or had a self-administration of medication assessment completed. *She expected a certified medication aide (CMA) or nurse to remain with a resident who was receiving a nebulizer treatment for the entire time the treatment was being administered if there was no self-administration of medications assessment completed and no physician's order for the resident to self-administer medications. 3. Interview on 5/21/25 at 8:57 a.m. with director of nursing (DON) B revealed: *It was her expectation for the nurse or CMA to remain with a resident while the resident was being administered a nebulizer treatment unless the resident had a self-administration of medications assessment completed and a physician's order to self-administer medications. *Leaving a resident alone while a nebulizer treatment was being administered would mean the resident was self-administering the	F 554		

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F 554	Continued From page 3 medication. *Resident 1 did not have a self-administration of medications assessment completed and did not have a physician's order to self-administer medications. 4. Review of the provider's June 2020 Administering Medications procedure revealed the staff member who was administering a medication was to, "Remain with the resident until he/she has taken all of his/her medicines." Review of the provider's 2/7/24 Assessment Process for Self-Administration of Medications policy revealed: *"An assessment for self-administration of medications will be completed upon admission to the facility if ordered from physician and assessed by an RN [registered nurse]." *"The physician will assess and update [the] order for self-administration every three months or earlier if needed." *"The assessment will always be reviewed by the interdisciplinary team at every care conference thereafter when the care team reviews the president's [resident's] plan of care." *"A Self Administration documentation process will be utilized for residents who do have an order for self-administration of medications in [EMR] as extra documentation that the resident is able to administer medications safely."	F 554		
F 582 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	F 582	Unable to change the outcome of the deficient practice for residents #1, 6, and 75 for failure to ensure the proper Medicare notices were completed accurately. The Medicare notices were updated to accurately reflect the required	7-5-25

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F 582	Continued From page 4 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.	F 582	formatting on 5/20/25. The executive director (ED) provided education to the MDS Coordinator and director of nursing (DON) on 6/12/25. The education included the information provided on the Form Instructions. The facility has determined that those residents on Medicare have the ability to be affected by this deficiency. The ED or designee will audit Medicare notices for accuracy once per week for four weeks and monthly for two additional months. The ED 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.	

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F 582	Continued From page 5 (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 proper Medicare notices were filled out completely and were in the required format for three of three sampled residents (1, 6, and 75) prior to their discharge from Medicare Part A skilled services. Findings include: 1. Review of the Entrance Conference Worksheet completed by the provider on 5/19/25 revealed three residents were identified as having been discharged from Medicare Part A skilled services: *Two of those residents (1 and 6) remained in the facility following their discharge from Medicare Part A skilled services. *One of those residents (75) was discharged home following her discharge from Medicare Part A skilled services. 2. Review of the Notice of Medicare Non-Coverage (NOMNC) form CMS-10123, with a revision date of 12/31/11, for resident 1 completed by executive director (ED) A revealed: *The provider's name, address, and phone number were not listed as required above the title of the form. *The Patient Number filled in by ED A was resident 1's Medicare Beneficiary Identifier (MBI), which was required not to be used.	F 582		

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F 582	Continued From page 6 *Resident 1's Medicare Part A Skilled Services Episode start date was 9/22/24. *Her last covered day on Medicare Part A Skilled Service was 11/8/24. *"The Effective Date Coverage of Your Current {insert type} Services Will End" was completed with the date "9-22-24", which was her admission date. *The first bullet point that explained "Your Medicare provider ... have determined that Medicare probably will not pay for your current {insert type} services ..." was not completed with the type of services ending. -The type of services ending should have been identified as skilled nursing. *The "How to Ask For an Immediate Appeal" section was to provide contact information in the fourth bullet point that indicated to "Call your QIO [Quality Improvement Organization] at: {insert QIO name and toll-free number of QIO} to appeal, ..." was not completed with the name and telephone numbers, including TTY (teletypewriter for people with hearing or speech difficulties) of South Dakota (SD)'s QIO. Review of resident 1's electronic medical record (EMR) revealed: *She was admitted on 9/22/24 with Medicare Part A covering her stay. *Her 9/22/24 admission and Medicare five-day Minimum Data Set (MDS) assessment's Medicare number entered at line A0600.B. was the same number listed on her NOMNC form above. *On 11/9/24, after her Medicare Part A stay ended, she remained in the facility as indicated on the Entrance Conference Worksheet. Interview on 5/20/25 at 10:08 a.m. with ED A	F 582		

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F 582	Continued From page 7 regarding resident 1's NOMNC form CMS-10123 revealed she: *Had completed and delivered the notice to resident 1 on 11/5/24. *Agreed that the provider's name, address, and phone number had not been provided as required. *Agreed the resident's MBI number had been used on the form, as specifically required not to. *Agreed that the type of services ending was not clearly identified. *Agreed that the QIO's name and toll-free phone number had not been provided as required. 3. Review of resident 6's Medicare notices completed by ED A revealed: *His Medicare Part A Skilled Services Episode start date was 10/25/24. *His last covered day on Medicare Part A Service was 11/21/24. Review of the NOMNC form CMS-10123, with a revision date of 12/31/11, for resident 6 completed by his representative on 11/22/24 revealed: *The provider's name was typed above the form's title. *The provider's address and phone number were not listed as required. *The Patient Number filled in by ED A was resident 6's MBI number, which was required not to be used. *"The Effective Date Coverage of Your Current {insert type} Services Will End" was completed with the date "10-25-24", which was his admission date. *The "type of services ending" section was not completed. -The type of services ending should have been	F 582		

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F 582	Continued From page 8 identified as skilled nursing. *The "How to Ask For an Immediate Appeal" section was not completed with the name and telephone numbers of SD's QIO. *The form was signed the day after his Medicare Part A skilled services had ended, which had not met the required two-day notice. Review of resident 6's 2024 Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 signed by resident 6's representative on 11/15/24 revealed: *The "Reason Medicare May Not Pay" section, which required a brief explanation to help understand why Medicare may deny payment, was blank. Review of resident 6's EMR revealed: *He was admitted on 10/25/24 with Medicare Part A covering his stay. *His 11/1/24 admission and Medicare five-day MDS assessment's Medicare number entered at line A0600.B. was the same number listed on his NOMNC form above. *On 11/22/24, after his Medicare Part A stay ended, he remained in the facility as indicated on the Entrance Conference Worksheet. Interview on 5/20/25 at 10:08 a.m. with ED A regarding resident 6's Medicare notices revealed she: *Had completed and delivered resident 6's SNF ABN notice to his representative on 11/15/24. *Agreed that the SNF ABN form had no reason provided for the "Reason Medicare May Not Pay" Section. *Had failed to provide resident 6's representative the NOMNC form on 11/15/24 when she	F 582		

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F 582	Continued From page 9 delivered the SNF ABN form. As a result, she provided the NOMNC to resident 6 on 11/22/24. She acknowledged that the NOMNC form was delivered late. -She confirmed the NOMNC form was given after his Medicare Part A stay had ended and had not met the required two-day advanced notice. *Agreed that the provider's address and phone number had not been provided as required. *Agreed the resident's MBI number had been used on the form, as specifically required not to. *Agreed that the type of services ending was not clearly identified. *Agreed that the QIO's name and toll-free phone number had not been provided as required. 4. Review of the NOMNC form CMS-10123, with a revision date of 12/31/11, for resident 75 completed by ED A revealed: *Her Medicare Part A Skilled Services Episode start date was 10/3/24. *Her last covered day on Medicare Part A Skilled Service was 12/30/24. *The provider's name was typed above the form's title. *The provider's address and phone number were not listed as required. *The Patient Number filled in by ED A was resident 75's MBI number, which was required not to be used. *"The Effective Date Coverage of Your Current {insert type} Services Will End" was completed with the date "10-3-24", which was her admission date. *The "type of services ending" section was not completed. -The type of services ending should have been identified as skilled nursing. *The "How to Ask For an Immediate Appeal"	F 582		

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F 582	Continued From page 10 section was not completed with the name and telephone numbers of SD's QIO. Review of resident 75's EMR revealed: *She was admitted on 10/3/24 with Medicare Part A covering her stay. *Her 10/10/24 admission and Medicare five-day MDS assessment's Medicare number entered at line A0600.B. was the same number listed on her NOMNC form above. *On 12/31/24, after her Medicare Part A stay ended, she was discharged to her home as indicated on the Entrance Conference Worksheet. Interview on 5/20/25 at 10:08 a.m. with ED A regarding resident 75's NOMNC form CMS-10123 revealed she: *Had completed and delivered the notice to resident 75 on 12/27/24. *Agreed that the provider's address and phone number had not been provided as required. *Agreed the resident's MBI number had been used on the form, as specifically required not to. *Agreed that the type of services ending was not clearly identified. *Agreed that the QIO's name and toll-free phone number had not been provided as required. 5. Interview on 5/20/25 at 10:08 a.m. with ED A revealed she: *Did not have a policy regarding the NOMNC and SNF ABN notices. *Was responsible for completing and providing the beneficiary notifications to residents and/or their representatives. *Had the instruction forms for the NOMNC and SNF ABN forms. *Expected the requirements, guidelines, and	F 582		

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F 582	Continued From page 11 instructions for the forms to be followed. *Agreed the form instructions for both the NOMNC and SNF ABN forms stated, "The beneficiary's/enrollee's MBI number must not be used." *Confirmed that she had used the residents' MBI numbers when completing the NOMNC forms for the past six years. *Agreed that the NOMNC forms had not clearly identified the type of services that were ending. *Confirmed that SD's QIO name and telephone numbers had not been provided as required on the NOMNC form. *She agreed that after the representative's signature, that "rep" or "representative" had not been written next to the signature as the form had instructed. 6. Review of the "Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055" and "Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123" revealed: *The SNF ABN Form Instructions included: -"Completing the SNF ABN" indicated in the "Reason Medicare May Not Pay" section, "the SNF must give ... a brief explanation of why the beneficiary's medical needs or condition do not meet Medicare coverage guidelines. The reason must be sufficient and specific enough to enable the beneficiary to understand why Medicare may deny payment." -Signature and Date indicated "If an authorized representative signs for the patient, write "(rep)" or "(representative)" next to the signature." *The NOMNC Form's Instructions included: -"When to Deliver the NOMNC ...The NOMNC must be delivered at least two calendar days before Medicare-covered services end..."	F 582		

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F 582	Continued From page 12 -For the Heading Contact information: "The name, address and telephone number of the provider that delivers the notice must appear above the title of the form." -For the Patient number: " ... The beneficiary's/enrollee's MBI number must not be used." -"{Insert type}: Insert the kind of service being terminated, i.e., skilled nursing, home health, comprehensive outpatient rehabilitation service, or hospice." -In the section How to Ask For an Immediate Appeal "Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than 12-point type."	F 582		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an	F 606	Information regarding CNA M had been provided to the South Dakota Department of Health (SD DOH) for review and based on their review, further action will be completed as directed. The executive director (ED) and social services designee (SSD) have reviewed and updated the Abuse, Neglect, and Misappropriation policy and procedures. The facility has determined that all have the ability to be affected by this deficiency. SSD or designee will audit all employee files for compliance with this regulation by 7/5/25. SSD or designee will audit all new employee files once per week for four weeks and monthly for two additional months. SSD or designee will present findings from audits at the monthly QAPI meetings and continue audits until the facility demonstrates sustained compliance as determined by the QAPI committee.	7-5-25

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F 606	Continued From page 13 employee, which would indicate unfitness for service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on personnel file review, interview, and policy review, the provider failed to ensure resident safety by employing one of one certified nursing assistant (CNA) M with a known documented history of abuse as prohibited in a provider's policy. Findings included: 1. Personnel file review on 5/20/25 at 3:37 p.m. of CNA M revealed: *She was hired on 10/28/24. *The facility had completed a background check prior to her hire. -That indicated CNA M was charged in 2018 for emotional/psychological abuse of a disabled adult. -CNA M had pleaded guilty to those charges. 2. Interview on 5/20/25 at 3:49 p.m. with executive director A and social service designee D revealed they: *Were aware of the charges listed on CNA M's background check. *Stated they had discussed those charges with CNA M directly. *Acknowledged that they had not contacted the Board of Nursing regarding the charges in relation to the staff's certification. *Acknowledged that no formal or informal check-ins had been conducted with CNA M since her start date related to her history of abuse. *Both agreed that, in the interest of resident safety, regular check-ins with CNA M should have been implemented from the beginning of her employment.	F 606		

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F 606	Continued From page 14 3. Review of the provider's undated Abuse, Neglect, and Misappropriation of Property Prevention Policy revealed: *Screening: "3. [Provider's name] will not employ or continue to employ, anyone, who has any history of documented patient abuse, neglect, or misappropriation of property."	F 606		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure four of fourteen sampled residents (3, 6, 11, and 20) with bed rails determined to not be restraints were accurately coded on the Minimum Data Set (MDS) assessments. Findings include: 1. Observation and interview on 5/19/25 at 10:16 a.m. with resident 3 revealed: *She was in her room, sitting in her wheelchair. *An electric list chair was in her room, and half bed rails were on both sides of her bed. *She stated she felt her electric lift chair and bed rails had not restrained her but were a help to her. Review of resident 3's electronic medical record (EMR) revealed: *She was admitted on 2/19/24. *Her 4/21/25 Brief Interview for Mental Status	F 641	MDS assessments for residents 3, 6, 11, and 20 were corrected and resubmitted by MDS coordinator on 5/21/2025. Review of all residents MDS have been audited for those residents with bed rails and no other inaccuracies found during audit. The MDS Coordinator and DON have reviewed and updated the Assistive Device and Restraints policy and procedures. The DON re-educated the MDS Coordinator on 6/12/25 regarding the importance of accurate assessments and coding for MDS assessments to ensure future compliance with this deficiency. The facility has determined that all residents have the ability to be affected by this deficiency. DON or designee will audit new Assistive Device Assessments and MDS section P (Restraints and Alarms) monthly for three months to ensure that bed rails are coded correctly on the MDS. DON 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.	7-5-25

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F 641	Continued From page 15 (BIMS) assessment score was 15, which indicated she was cognitively intact. *She had signed a "Side Rails Informed Consent and Release" on 9/10/24. *A 10/15/24 physician order stated, "May use specialized pull up bar at HOB [head of bed] for bed mobility, repositioning, and getting in/out of bed per resident request." *Her 11/28/24 initial Assistive Device Assessment, and her 1/28/25 and 4/17/25 Assistive Device Assessments all had documentation that indicated: -The bed rails had not been used as a restraint. -"Use of ... bed rails does not restrict her freedom of movement or normal access to her body." -"Bed rails will improve her ability to repo [reposition] self in bed & transfer in/out of bed & provide her with comfort & autonomy ... " -"[Resident 3] is cognitively intact and is able to understand/demonstrate proper use of bedrails ..." *MDS assessments documented her bed rails in section P "Restraints and Alarms" as a restraint that was used daily on her: -11/4/24 quarterly review assessment. -1/27/25 annual assessment. -4/21/25 quarterly review assessment. *Her current 5/19/25 care plan indicated the use of her side rails as a support to her care had been initiated on 11/7/24 which included: -"Half rails up as per Dr.s [doctor's] order to assist with bed mobility." -"Observe for injury or entrapment related to side rail use." -"Assess quarterly and with significant changes." 2. Observation on 5/19/25 at 10:30 a.m. of resident 6 in his room revealed: *He was lying on his bed with a blanket over him	F 641		

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F 641	Continued From page 16 and his eyes closed. *He did not respond to the knock on his door or verbal greeting. *He had side rails on his bed. Review of resident 6's EMR revealed: *He was admitted on 8/14/24. *His 4/13/25 BIMS assessment score was 15, which indicated he was cognitively intact. *He had signed a "Side Rails Informed Consent and Release" on 9/10/24. *A 10/15/24 physician order stated, "May use upper side rail for bed mobility, repositioning, and getting in/out of bed per resident request." *His 11/28/24 initial Assistive Device Assessment, and his 1/15/25 and 4/10/25 Assistive Device Assessments had documentation that indicated: -The bed rails had not been used as a restraint. -"Use of ... bed rails does not restrict his freedom of movement or normal access to his body." -"Bed rails will improve [his] ability to repo [reposition] self in bed & transfer in/out of bed & provide him with comfort & autonomy ... " -"[Resident 6] is cognitively intact and is able to understand/demonstrate proper use of bedrails ..." *MDS assessments documented his bed rails in section P "Restraints and Alarms" as a restraint that was used daily on his: -11/1/24 admission assessment following his 10/22/24 to 10/25/24 hospitalization. -1/20/25 quarterly review assessment. -4/14/25 quarterly review assessment. *His current 5/20/25 care plan indicated that the use of his side rails as a support to his care had been initiated on 11/7/24 which included: -"I use a side rail to maximize independence with turning and repositioning in bed." -"[H]half rails up as per Dr.s order to assist with	F 641		

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F 641	Continued From page 17 bed mobility." -"Observe for injury or entrapment related to side rail use." 3. Observation on 5/18/25 at 3:37 p.m. of resident 11's room revealed: *She had a lift chair. *Her side rail was not up but was able to be raised and lowered on her bed. Interview on 5/19/25 at 4:00 p.m. with CNA U revealed: *Resident 11 had a side rail affixed to her bed that could be raised and lowered. *Resident 11 used the side rail to help with transfers in and out of bed. Review of resident 11's EMR revealed: *She was admitted on 9/13/23. *Her 3/4/25 BIMS assessment score of 15, which indicated she was cognitively intact. *Her care plan indicated she used a side rail "to maximize independence with turning and repositioning in bed. *The 2/27/25 Assistive Device Assessment had documentation that indicated: - "Bed rails will improve her ability to reposition self in bed and transfer in/out of bed and provider her with comfort & autonomy. A lift chair or recliner w/ [with] foot rest elevated would provide comfort, safety, & prevent skin breakdown by providing pressure relief." -"Is able to understand/demonstrate proper use of bedrails, recliner, & [and] lift chair." -"Use of a recliner w/ elevated foot rest/lift chair/bed rails does not restrict her freedom of movement or normal access to her body." -"No" was selected to the question "Is the device being used as a restraint?"	F 641		

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F 641	Continued From page 18 *MDS assessments documented her bed rails in section P "Restraint and Alarms" as a restraint that was used daily on her: -12/9/24 quarterly review assessment. -3/3/25 quarterly review assessment. 4. Observation and interview on 5/19/25 at 4:12 p.m. with resident 20 in his room revealed: *There was a black P-shaped side rail on the left side of his bed and a lift chair. *He used the side rail to help him move while in bed. *He stated his son had brought the side rail to the facility and installed it on his bed so he could move over in bed without assistance from staff. *He denied the side rail prevented him from getting out of bed and he was able to operate the lift chair without staff assistance. Review of resident 20's electronic medical record (EMR) revealed: *He was admitted on 3/14/25. *His 3/26/25 Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated he was moderately cognitively impaired. *His power of attorney (POA) had signed Side Rail Informed Consent and Release form on 3/17/25. *His care plan indicated, "I use a physician prescribed half bed rail to maximize independence with turning and repositioning in bed." *His 3/14/25 Assistive Device Assessment was signed by MDS coordinator/infection preventionist (IP) C which documented: -"Bed rails will improve his ability to repo [reposition] self in bed & transfer in/out of bed & provide him with comfort & autonomy."	F 641		

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F 641	Continued From page 19 -"Is able to understand/demonstrate proper use of bedrails, recliner w/ elevated foot rest & [and] lift chair." -"Use of a recliner w/ elevated foot rest/lift chair/bed rails does not restrict his freedom of movement or normal access to his body." -"No" was selected to the question "Is the device being used as a restraint?" *His 3/21/25 admission MDS assessment documented his bed rails in section P "Restraint and Alarms" as a restraint that was used daily. 5. Interview on 5/20/25 at 4:18 p.m. with MDS Coordinator/IP C regarding coding of physical restraints on the resident's MDS for "Physical Restraints" revealed: *The "Resident Matrix" provided to the survey team on 5/18/25 had identified four (3,6, 11, and 20) of the current twenty-two residents who had a physical restraint in use. *Director of nursing (DON) B completed the residents' initial Assistive Device assessments. *MDS Coordinator/IP C completed those assessments quarterly. *She agreed the Assistive Device assessments documented the side rails had not met the regulatory definition of a physical restraint and were not used as restraints. *She agreed she had made mistakes completing the MDS assessments for residents who were using bed rails. *She stated that in her training as a nurse, she had been told that a side rail on a bed was a restraint. That is why she had coded side rails as a restraint on the residents' MDS assessments. Interview on 5/20/25 at 5:15 p.m. with DON B regarding bed rails revealed she: *Had worked at the facility for several years and	F 641		

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F 641	Continued From page 20 became DON in September 2024. *Had completed the residents' initial Assistive Device assessments and MDS Coordinator/IP C completed the following quarterly assessments. *Agreed the residents' bed rails above were assessed and determined not to be physical restraints and the coding of them as physical restraints in the MDS assessment had been inaccurate. 6. Review of the provider's November 2024 Assistive Device and Restraints policy revealed: *"Purpose: To ensure the appropriate assessment, provisions, and use of assistive devices and physical restraints for residents, promoting their independence, safety, and quality of life, in compliance with CMS [Center for Medicare and Medicaid Services] regulations, South Dakota state laws, and evidence-based practices." *"Physical Restraints: Any manual method or physical method of mechanical device, material, or equipment attached to or adjacent to the resident's body that the individual cannot remove easily and which restricts freedom of movement or normal access to one's own body." *"Assistive Device: Items used to increase, maintain, or improve functional capabilities, including but not limited to, Geri-chairs, Rock-King Chairs, Bed Rails, Lift Chairs, Reclining Chairs, and Concave Mattresses."	F 641		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and	F 655	Baseline care plans for residents #3, 19, 20, and 175 were completed and each was given a summary of their baseline care plan. A copy of the summary, signed by the resident, resident's representative if applicable, and the facility's representative was placed in the medical record.	7-5-25

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F 655	Continued From page 21 implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.	F 655	All other current residents' care plans were audited on 6/4/25 and it was determined that all have received their baseline care plans. The facility's Care Plan policy and procedures were reviewed and revised as necessary regarding baseline care plans. All interdisciplinary care plan team members responsible for writing baseline care plans will be re-educated on 6-24-25 on the facility's policy and procedure for developing baseline care plans, which indicates procedures for providing the resident with a written summary of their baseline care plan to ensure future compliance with this deficiency. The facility has determined that all have the ability to be affected by this deficiency. DON or designee will complete weekly audits of new residents having completed and signed baseline care plans within 48 hours after admission - once per week for four weeks and monthly for two additional months. DON 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.	

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F 655	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to ensure baseline care plans had been completed and a written summary of the baseline care plans had been provided to the resident or their representative for four of four recently admitted sampled residents (3, 19, 20, and 175) within 48 hours of their admission to the facility. Findings include: 1. Interview on 5/19/25 at 10:00 a.m. with resident 3 revealed: *She had admitted to the facility from the provider's assisted living facility last year. *She could not recall if her care needs and services were discussed with her after her admission. *She had not received a summary or paper copy of her baseline care plan or a list of her medications. Review of resident 3's electronic medical record (EMR) revealed: *Her 4/21/25 Brief Interview for Mental Status (BIMS) assessment score was 15, which indicated she was cognitively intact. *She was admitted on 2/19/24. *There were no progress notes from 2/19/24 to 2/21/24 that addressed her baseline care plan or indicated a baseline care plan had been provided to the resident or her representative. *The first progress note pertaining to care planning was titled Care Conference and dated 2/26/24 "Admission care conference set for 3/6/2024 at 9:30am with son, [resident 3's son] invited to attend with [resident 3]. *Her Baseline Care Plan assessment, initiated on	F 655		

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F 655	Continued From page 23 2/19/24, was still "In Progress" in the EMR and included: -Minimum Data Set (MDS) coordinator/infection preventionist (IP) C had signed the assessment on 2/20/24. -Resident 3's representative had signed the assessment on 2/28/24. --That was nine days after resident 3's admission to the facility. Interview on 5/20/25 at 4:55 p.m. with MDS coordinator/IP C regarding resident 3's baseline care plan revealed: *She had signed the resident's Baseline Care Plan assessment. *She agreed the assessment's status was "In Progress" and had not been locked/completed. -She agreed that resident 3's son had signed the assessment on 2/28/24, nine days after the resident's admission, and that had not met the required time frame. 2. Observation on 5/19/25 at 9:49 a.m. with resident 19 revealed: *He was in bed and his speech was limited. *A hospice registered nurse (RN) was in the room with the resident. -She stated on good days he would give a thumb up or thumb down to communicate. -He had not used his thumbs to communicate that day. Review of resident 19's EMR revealed: *He admitted to the facility on 4/24/25 on hospice care with the hospice service which provided that care at this home. *His 5/1/25 MDS admission assessment indicated the resident was rarely/never understood and that his cognitive skills for daily	F 655		

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F 655	Continued From page 24 decision making was modified independence. *His Baseline Care Plan assessment, initiated on 4/23/25, was still "In Progress" and had not been finalized in the EMR. -Signatures of Staff Completing the Baseline Care Plan included: --Director of nursing (DON) B had signed the assessment on 4/24/25. --Social service designee D had signed the assessment on 4/28/25, which was four days after his admission and did not meet the 48-hour required timeframe. Surveyor requested to review resident 19's Baseline Care Plan. The provider gave a nine-page paper copy that included resident 19's representative's signature. There was no date that indicated when his representative had received it. 3. Interview on 5/20/25 at 4:55 p.m. with MDS coordinator/IP C revealed: *She or DON B completed the Baseline Care Plan assessments for the residents. *She expected that the residents' Baseline Care Plans be completed within 48 hours of their admission. *She stated that DON B had signed resident 19's Baseline Care Plan. *She acknowledged that completing the baseline care plan and its requirements was an area for improvement. *She agreed that some resident baseline care plans had not been completed within 48 hours of their admission, and the baseline care plans had not been given to the resident or representative as required. Interview 5/20/25 at 5:15 p.m. with DON B	F 655		

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F 655	Continued From page 25 regarding resident baseline care plans revealed: *Either she or MDS coordinator/IP C had been completing the Baseline Care Plan assessments. *She had signed resident 19's Baseline Care Plan assessment. *She agreed the assessment's status was "In Progress" and had not been locked/completed. *She recalled providing the baseline care plan to resident 19's wife but could not remember the date. *She agreed that some of the baseline care plans had not been provided to the family or representative within the required 48-hour timeline. *She agreed they were not consistently meeting the requirements for the baseline care plan. 4. Review of resident 20's EMR revealed: *He was admitted on 3/14/25. *His 3/14/25 baseline care plan did not include documentation for, "Active diagnoses contributing to admission" and resident 20's wishes related to advanced directives and code status. *On 3/14/25 Minimum Data Set (MDS) coordinator/infection preventionist C signed that she had completed the baseline care plan. *Resident 20's power of attorney (POA) signed the baseline care plan, but a date was not documented as to when the baseline care plan was signed. 5. Review of resident 175's EMR revealed: *She was admitted on 5/12/25. *Social service designee D signed that she had completed the baseline care plan but did not date when she signed it. *Director of nursing (DON) B signed and dated resident 175's baseline care plan as having been completed on 5/18/25.	F 655		

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F 655	Continued From page 26 *Resident 175 signed her baseline care plan on 5/19/25 which did not meet the 48-hour timeframe. 6. Interview on 5/20/25 at 4:19 p.m. with MDS coordinator/infection preventionist C revealed: *She or DON B attempted to complete all residents' admission assessments, but any nurse could have completed them. *Baseline care plans were to be completed on the day of the resident's admission by the nurse who was admitting the resident. *Baseline care plans were to be completed, printed, reviewed with the resident or the resident's representative, and signed after the by the resident or resident representative within 48 hours of admission. *She was aware the baseline care plans had not been completed, reviewed, and signed within the required 48-hour time frame. 7. Review of the provider's October 2021 Care Plan Policy and Procedure revealed: *"Care plan will be developed by an interdisciplinary team with participation of the resident, family, and/or representative (when available)." *"Upon admission,[the] resident will be assessed by the Charge Nurse and a baseline care plan will be developed with information gathered from the resident and [the] resident's family."	F 655		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure	F 700	Bedrail for Resident #20 was properly installed. Resident #11 and 20 have been educated on risks of use versus benefits. Residents #11 and 20 will have updated bed rail assessments completed by 7/5/25. All residents with bed rails will be audited by 7/5/25 to ensure consent forms, education, and assessments were completed.	7-5-25

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F 700	Continued From page 27 correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure: *A bed rail was properly installed for one of one sampled resident (20). *Entrapment risk was assessed for two of two sampled residents (11 and 20) with bed rails. *There was documented resident-specific risk versus benefits education provided for the informed consent for use of bed rails for two of two sampled residents (11 and 20). *Alternatives were attempted and documented prior to the installation of bed rails for two of two sampled residents (11 and 20). *There was routine maintenance of the bed rails for two of two sampled residents (11 and 20). Findings include: 1. Observation on 5/19/25 at 8:37 a.m. of resident	F 700	The Maintenance Director will complete an Entrapment Risk Assessment for any new bedrail applications and then quarterly thereafter. The Maintenance Director will perform routine maintenance checks quarterly. DON, MDS Coordinator, and executive director (ED) will review and revise as necessary the Assistive Devices & Restraints policy and procedures. The Assistive Devices assessment was revised to include the required education and alternative documentation. An all-staff meeting will be held on 6/24/25 to provide education on citation F700, policy and procedure, and the requirements to ensure future compliance with this policy. The facility has determined that all residents have the ability to be affected by this deficiency. DON or designee will audit that bed rails are properly installed and assessments/ maintenance have been completed and documented as required once per week for 4 weeks then monthly for two more months to ensure compliance. DON 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.	

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F 700	Continued From page 28 20's room revealed there was a black P-shaped bed rail on the left side of his bed. Observation and interview on 5/19/25 at 4:12 p.m. with resident 20 in his room revealed: *He used the bed rail to help him move while in bed. *He stated his son had brought the bed rail to the facility and installed it on his bed. *The semi-circular opening to the P-shaped black bed rail (zone 1) measured eleven inches by five inches. -The opening in the bed rail was large enough for a body part to become entrapped and had potential for injury. *The bed rail lifted the mattress and bed springs when it was pulled away from the bed. *When the bed rail was pulled toward the foot of the bed it tilted approximately four inches from its resting position. *The bed rail was affixed to a wooden board which was secured to the bed frame and springs with a black strap. *The black strap was crossed over the board and around the bed springs. Review of resident 20's electronic medical record (EMR) revealed: *He was admitted on 3/14/25. *His 3/26/25 Brief Interview of Mental Status (BIMS) assessment score was 11, which indicated he was moderately cognitively impaired. *He had a diagnosis of Parkinson's disease (a disorder of the central nervous system that affects movement). *His care plan indicated, "I use a physician prescribed half bed rail to maximize independence with turning and repositioning in bed."	F 700		

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F 700	Continued From page 29 -It did not include which side of the bed the bed rail was on or what type of bed rail it was. *His 3/14/25 Assistive Device Assessment indicated the bed rails were used to "improve his ability to repo [reposition] self in bed & [and] transfer in/out of bed & provide him with comfort & autonomy." -A physical therapy or occupational therapy consult was not obtained. -There was no documentation that indicated entrapment risk was assessed, or alternatives were attempted prior to the installation of the bed rails. *The risk versus benefits documented on the Side Rail Informed Consent and Release were not specific to resident 20's needs and risk factors such as his cognition and his Parkinson's diagnosis. 2. Observation and interview on 5/19/25 at 5:01 p.m. with director of nursing (DON) B in resident 20's room revealed: *The P shaped bed rail was brought in by resident 20's family. *She thought the facility's maintenance department staff had installed the side rail. *She agreed the opening within the side rail was large enough for a head or body part to become entrapped, the side rail was not secure, and it was a safety risk for the resident. 3. Interview on 5/20/25 at 9:15 a.m. with maintenance supervisor G revealed: *Resident 20's family had brought in the bed rail and installed it on the resident's bed. *He did not complete assessments for potential risk of entrapment related to bed rails. *There was no scheduled routine maintenance on the residents' beds or side rails.	F 700		

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F 700	Continued From page 30 *It was his expectation that housekeeping staff would notify him if they identified an issue with a bed or side rail. 4. Interview on 5/20/25 at 10:25 a.m. with housekeeping laundry supervisor F revealed: *He expected the housekeepers to notify maintenance if an issue with a bed or bed rail was identified. *Housekeeping was not responsible for ensuring correct installation and maintenance of the side rails. 5. Interview on 5/20/25 at 10:54 a.m. with certified nursing assistant (CNA) N revealed: *Resident 20 used his side rail to sit up and scoot forward while he was in bed. *She did not feel the opening in resident 20's side rail was a safety risk for him, but did state there were other residents who had poor cognition that wandered into other resident rooms, and she felt the size of the opening on the bed rail may be a safety risk for those residents. *She verified resident 20's bed was an adjustable bed. *She stated she would notify the charge nurse and maintenance if she identified a loose bed rail or a bed rail in need of repair. 6. Review of resident 11's EMR revealed: *She was admitted on 9/13/23. *She had a 3/4/25 BIMS assessment score of 15, which indicated she was cognitively intact. *Her diagnoses were lack of coordination, muscle weakness, and dementia. *Her care plan indicated she used a bed rail "to maximize independence with turning and repositioning in bed. -It did not include which side of the bed the bed	F 700		

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F 700	Continued From page 31 rail was on. *The 2/27/25 Assistive Device Assessment indicated, "Bed rails will improve her ability to reposition self in bed and transfer in/out of bed and provide her with comfort & autonomy." -It did not include documentation of education provided, alternative attempted, or an assessment for risk of entrapment. *The risk versus benefits documented on her 9/10/24 Side Rail Informed Consent and Release were not specific to resident 11's needs and risk factors such as her lack of coordination and muscle weakness. 7. Interview on 5/19/25 at 4:00 p.m. with CNA U revealed: *Resident 11 had a bed rail affixed to her bed that could be raised and lowered. *Resident 11 used the bed rail to help with transfers in and out of bed. 8. Interview on 5/20/25 at 4:19 p.m. with Minimum Data Set (MDS) coordinator/infection preventionist (IP) C revealed: *DON B completed the Assistive Device Assessments on admission, and MDS coordinator/IP C completed them quarterly, annually, and with a significant change with the resident's MDS assessment. *If a bed rail was requested for a resident MDS coordinator/IP C would notify DON B of the request. DON B would complete the Assistive Device Assessment, obtain consent from the resident or resident representative, and get an order from the resident's physician for the use of bed rails. *There was no process in place to assess for a resident's entrapment risk. *There was a place on the Assistive Device	F 700		

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F 700	Continued From page 32 Assessment to document education provided related to the assistive device, but she did not provide that education quarterly to the residents or representatives. *Alternatives attempted prior to the installation of a bed rail were not documented. *She was not aware of any alternatives that were attempted prior to the installation of the bed rails for residents. *All the bed rails in the facility, besides resident 20's, were affixed to the beds. *There was no process in place to determine if a bed rail was installed and functioning properly. 9. Interview on 5/21/25 at 8:57 a.m. with DON B revealed: *There were no documented alternative attempted prior to the installation of a bed rail documented in the residents' records. *The facility attempted to consult the therapy department prior to the installation of bed rails related to services the therapy department may be able to provide for the resident, and the resident's ability to properly use a bed rail, but that was not documented in the resident's EMR. *The risks versus benefits included on the Side Rails informed Consent and Release was not individualized to each resident's unique needs and risk factors. *The facility did not assess the resident's risk for entrapment related to the use of bed rails. *The facility did not complete and document scheduled maintenance to the resident beds or bed rails as was indicated in the provider's policy. *Manufacturers' recommendations and specifications were not followed with the application of resident 20's bed rail. *She verified resident 20's bed rail was not installed properly, was not secure, and it was a	F 700		

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F 700	Continued From page 33 safety risk related to potential entrapment. 10. Review of the provider's undated manufacturer's instructions for the Stander bed rail revealed: *"There is a risk of entrapment associated with all bed rails and other similar bedside mobility aides." *"Entrapment can result in serious injury and death." *"BEFORE INSTALLING THIS PRODUCT, YOU MUST ENSURE THAT IT IS SAFE TO USE ON YOUR BED AND MATTRESS." *"Failure to properly install and use these components [clamps, safety straps, and other means] significantly increases the risk of entrapment." *"DO NOT use on adjustable beds." *"If this product is used in a nursing home, assisted living center, or a similar facility, follow these instructions and all of the institution's Bed Rail/Handle installation policies. If this product does not comply with those installation policies, do not install this product." *"ENTRAPMENT ZONES - Zone 1: Within the Rail- Any open space between the perimeters of the rail can present a risk of head entrapment. The FDA [Food and Drug Administration] recommended space is less than 4.75 in [inches]". *"If the safety strap provided is not properly secured, the product may move into an unsafe position which increases the danger of entrapment. See enclosed ASSEMBLY INSTRUCTIONS for proper use of the straps." *"ASSEMBLY INSTRUCTIONS -Extend both straps (C) below mattress to the opposite side of bed. Unbuckle strap and wrap one end between mattress and BED FRAME (or	F 700		

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F 700	Continued From page 34 board) and re-buckle strap". 11. Review of the provider's undated Resident LTC [long term care] Bed Service Manual revealed: *"Use only accessories specifically identified for use with the Resident LTC bed. The use of accessories not identified for this bed could compromise the safety of the bed." *"Use only Hill-Rom parts and accessories. Do not modify the bed without authorization from Hill-Rom." *"Perform preventative maintenance annually to ensure all bed features are functioning as originally designed. Pay particular attention to safety features regarding the Resident LTC bed including but not limited to: -Siderail latching mechanism". 12. Review of the provider's November 2024 Assistive Device and Restraints policy revealed: *"Purpose: To ensure the appropriate assessment, provisions, and use of assistive devices and physical restraints for residents, promoting their independence, safety, and quality of life, in compliance with CMS [Center for Medicare and Medicaid Services] regulations, South Dakota state laws, and evidence-based practices." *"Assistive Device: Items used to increase, maintain, or improve functional capabilities, including but not limited to, Geri-chairs, Rock-King Chairs, Bed Rails, Lift Chairs, Reclining Chairs, and Concave Mattresses." *"Our facility is committed to providing residents with access to assistive devices as part of their individualized care plans. These devices must be safe, functional, and appropriate for the resident's clinical and functional needs."	F 700		

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F 700	Continued From page 35 *"Assistive Devices -1. The Assistive Device Assessment in [EMR] will be completed upon admission, quarterly with MDS, with a significant change in condition, or upon request to determine the appropriateness and continued appropriateness of devices based on the resident's physical and cognitive abilities. -2. The assessment will be reviewed by the Interdisciplinary Team, Resident/Representative, and Physician. -3. Resident/Representative will be informed of appropriate devices and receive education and training on proper use of device if utilized. -4. Resident/Representative consent, education, and justification/functional need for device will be documented within the Assistive Device Assessment in [the EMR]. -5. Any assistive device utilized will be added to the resident's care plan." *"Bed Rails: Resident/Representative will review and sign the Bed Rail Informed Consent and Release form to provide education regarding safety, risks, benefits, and use."	F 700		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable	F 812	Unable to change the outcome of the deficient practice for monitoring and documenting dishwasher wash and rinse cycle temperatures and chlorine sanitizer concentration levels. The Food Service Supervisor has reviewed the Dish Machine Temperature Log and confirmed that the policy is correct in that it requires checking dish machine temperatures for the wash and rinse cycles at each meal.	7-5-25

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F 812	Continued From page 36 safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on policy review, observation, record review, and interview, the provider failed to ensure one of one low-temperature dishwasher: *Wash and rinse cycle temperatures were monitored and documented at each meal according to their policy. *Chlorine sanitizer concentration level was monitored and documented at least once per shift according to accepted food safety standards of practice. Findings include: 1. Review of the facility's undated Dish Machine Temperature Log revealed: Policy: "Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes." Procedure: "The director of food and nutrition services will post a log near the dish machine for the staff to document temperatures." "2. Staff will record dish machine temperatures for the wash and rinse cycles at each meal. The director of food and nutrition services will spot check this log to assure temperatures are appropriate and staff is correctly monitoring dish machine temperatures." 2. Observation on 5/18/25 at 3:15 p.m. in the	F 812	The Food Service Supervisor conducted training with the dietary team on 5/20/25. Education regarding dishwasher wash and rinse cycle temperatures and chlorine sanitizer concentration levels monitoring and documentation was provided to ensure future compliance with this policy. The facility has determined that all have the ability to be affected by this deficiency. Food Service Supervisor or designee will audit temperature logs once daily for two weeks, then once weekly for two weeks and monthly for two more months to ensure staff are monitoring and documenting dishwasher wash and rinse cycle temperatures and sanitizer concentration levels. Food Service Supervisor 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.	

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F 812	Continued From page 37 kitchen revealed: *The mechanical dishwashing machine had a label on it that read: -"Wash Temperature 120 degrees F [Fahrenheit] minimum". -"Rinse Temperature 120 degrees F minimum". *The logs for the dishwasher temperatures for May 2025 were on a clipboard on the wall and included: -Columns to record "Wash Temp Rinse Temp Rinse PPM [parts per millimeter] Staff Initials" for AM [morning] and PM [evening]. -The AM rinse temperature column had recorded temperatures from 5/1/25 through 5/17/25. --Those temperatures ranged from 120 degrees F to 127 degrees F. *There was no temperatures documented in the PM column. *Review of additional dishwasher temperature logs revealed: -For April 2025: --Columns to record "Wash Temp Rinse Temp Rinse PPM Staff Initials" for AM and PM. -The AM wash temperature column had recorded temperatures from 4/15/25 through 4/25/25. --Those temperatures ranged from 118 degrees F to 121 degrees F. -The AM rinse temperature column had recorded temperatures from 4/15/25 through 4/30/25. --Those temperatures ranged from 122 degrees F to 124 degrees F. *There was no temperatures documented in the PM column. *At the bottom of the monitoring sheet, it reads, "Record dish machine temperatures and sanitizer PPM every AM and PM." 3. Observation and record review on 5/18/25 at 3:25 p.m. in the kitchen revealed:	F 812		

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F 812	Continued From page 38 *The dishwasher chlorine sanitizer monitoring sheets had been filled out once a day. -The chlorine sanitizer levels documented were within acceptable standards of practice. -No documentation indicated it was monitored and documentated at least once per shift as required according per standing of practice. 4. Interview on 5/18/25 at 3:35 p.m. with food service supervisor E revealed she: *Had been the kitchen supervisor since 5/12/22. *Confirmed they been monitoring and documenting the dishwasher sanitizer chlorine levels only. *Stated she checked the wash temperatures and rinse temperatures, but had not written them down. -until last month, when the dishwasher vendor's service department informed her, they needed to start documenting the temperatures, but only the rinse temperature. *Agreed if proper sanitization was not followed; it could have caused foodborne illness. *Was unaware the facility's policy had stated the staff would record the wash temperature and rinse temperature of the dishwasher at each meal. *Was unaware she needed to check the dishwasher chlorine levels per shift according to food safety standards of practice. 5. Observation on 5/21/25 at 10:39 a.m. in the kitchen revealed: *The logs for the dishwasher temperatures for May 2025 had been updated to include each meal. *From 5/19/25 through 5/21/25 the dishwasher temperatures ranged from 120 degrees F to 139 degrees F.	F 812		

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F 812	Continued From page 39 6. Interview on 5/20/25 at 4:15 p.m. with executive director A revealed she: *Confirmed no gastrointestinal (GI) outbreak had occurred in the facility *Expected the staff to follow the facility policy for the dishwasher to ensure proper sanitization of the dishes.	F 812		
F 813 SS=E	Personal Food Policy CFR(s): 483.60(i)(3) §483.60(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Safe food storage temperatures were monitored and documented. *Soiled containers were removed, cleaned, or discarded. *Items stored in the refrigerators were approved, dated, and monitored for discarding according to the provider's policy for six of six sampled residents' (2, 3, 5, 8, 12, and 16) with personal refrigerators. Findings include: 1. Observation and interview on 5/19/25 at 10:08 a.m. with resident 3 in her room revealed: *There was a personal refrigerator in her room. *The thermometer in her refrigerator read 34° Fahrenheit (F). *She stated a maintenance staff person had brought in the thermometer "a couple days ago." *There was no documentation of the refrigerator	F 813	Soiled containers have been removed, cleaned, or discarded from refrigerators for residents #2, 3, 5, 8, 12, and 16. Items stored in refrigerators for residents #2, 3, 5, 8, 12, and 16 have been approved and dated. Food storage temperatures will be monitored and documented daily by nursing staff. Items in refrigerators will be monitored for discarding according to provider's policy daily by nursing staff. The Food Service Supervisor and DON have reviewed and updated the Personal Refrigerators policy and procedures. An all-staff meeting will be held on 6/24/25 to provide education on citation F813, policy and procedures, and the requirements to ensure future compliance with this policy. The facility has determined that all residents have the ability to be affected by this deficiency.	7-5-25

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F 813	Continued From page 40 temperatures seen on or near the refrigerator. *She stated the staff had not monitored the temperature of her refrigerator. *The inside of her refrigerator contained: -A 16-ounce (oz) container of heavy whipping cream with a best by (BB) date of 7/13/25. -A bowl of strawberries that was not dated. -A glass pint jar of home-canned beets that was not labeled or dated. -A glass jar of Maple Bacon Onion Jam that had been opened but was not dated. -An unopened small glass container of Hot Pepper Jam. -An unopened small glass container of Maine Maple Champagne Mustard. *She stated the strawberries were from the Mother's Day event on Sunday, 5/11/25, which was eight days ago, and she was worried that some of them were turning soft. Review of resident 3's electronic medical record (EMR) on 5/21/25 of her May 2025 Treatment Administration Record (TAR), which included a schedule for "Record Temperature of personal refrigerator in resident's room every night shift" with a Start Date of 5/19/25 at 1800 (6:00 p.m.) revealed the following recorded temperatures: *42° F on 5/19/25. *37° F on 5/20/25. 2. Interview and observation on 5/19/25 at 9:22 a.m. in resident 5's room revealed: *She had a refrigerator in her room. *There was no temperature log with the refrigerator temperatures posted on or near the refrigerator for May 2025. *There was a thermometer on the inside of the refrigerator door that read 33° Fahrenheit (F). *She stated the refrigerator temperatures were	F 813	DON or designee will audit documentation of temperatures and items stored in personal refrigerators once per week for four weeks and monthly for two additional months. DON 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.	

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F 813	Continued From page 41 not checked daily by staff. *Her daughter would check the refrigerator every few days when she visited. *The resident would keep her drinks and snacks in the refrigerator, so they were available to her when she wanted them. 3. Observation on 5/20/25 at 10:42 a.m. in resident 5's room of her refrigerator revealed: *The temperature read 32°F. *The top shelf contained the following items: -A 64-ounce plastic bottle of opened prune juice with no open date. -Four 4-ounce opened vanilla pudding cups with no open dates. -One metal Christmas canister with a lid that contained candy. -One small Styrofoam cup with a lid that contained an unidentified liquid that was unlabeled and had not been dated. *The bottom shelf contained the following items: -Three unlabeled plastic bottles that contained a dark liquid and one was wrapped in a plastic bag. 4.. Interview and observation on 5/19/25 at 11:19 a.m. in resident 16's room revealed: *She had a refrigerator in her room. *There was no temperature log with the refrigerator temperatures posted on or near the refrigerator for May 2025. *There was a thermometer on the inside of the door that read 48°F. *She stated the refrigerator temperatures were not checked daily by staff. *She stated that she took care of her refrigerator and would clean it as needed. *She stated that she would "mainly keep her soda in it."	F 813		

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F 813	Continued From page 42 5. Observation on 5/20/25 at 10:35 a.m. in resident 16's room of her refrigerator revealed: *The temperature read 40°F. *The top shelf contained the following items: -One partially eaten unidentified meat and cheese sandwich stored in a Ziploc bag that was not labeled or dated. *The bottom shelf contained the following items: -One navy blue insulated cup with a lid that contained an unidentified liquid. *The refrigerator door contained a soiled navy-blue washcloth. 4. Observation and interview on 5/18/25 at 3:44 p.m. with resident 12 in her room revealed: *There was a personal refrigerator in her room. *There was no documentation of refrigerator temperatures seen on or near the refrigerator. *She did not think the staff were checking the temperature of her refrigerator. *There had been a piece of paper that the temperatures were documented on when she was admitted to the facility, but that paper was no longer being hung on her refrigerator. *Her refrigerator contained canned unopened beverages and open empty pop bottles in her freezer *She stated when her freezer needed to be defrosted, she would notify a staff member, and the staff would defrost it. 5. Observation and interview on 5/19/25 at 9:19 a.m. with resident 8 in her room revealed: *There was a personal refrigerator in her room. *There was no documentation of refrigerator temperatures seen on or near the refrigerator. *Her daughter had brought in the refrigerator for her to use. *She did not know if staff monitored and	F 813		

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F 813	Continued From page 43 documented the temperature of her refrigerator. *The temperature in the refrigerator was 33 degrees Fahrenheit. *She had canned beverages in her refrigerator. *There was a brown dried substance on the lower shelf of the refrigerator. 6. Observation and interview on 5/19/25 at 9:23 a.m. with resident 2 in her room revealed: *There was a personal refrigerator in her room. *There was no documentation of refrigerator temperatures seen on or near the refrigerator. *She did not know if the staff monitored and documented the temperature of her refrigerator. *The temperature of the refrigerator was 35 degrees Fahrenheit. *She stated she used her refrigerator for prepackaged beverages and if her family brought in food for her. 7. Interview and observation on 5/19/25 at 3:44 p.m. with registered nurse (RN) H revealed: *The nurse on the night shift was responsible for checking the temperatures of the personal refrigerators in the resident rooms. *She stated the temperatures were to be documented on a piece of paper on the resident's refrigerator. *She verified there were no forms for documentation on the residents' refrigerators. Interview on 5/19/25 at 3:47 p.m. with director of nursing (DON) B regarding the residents' refrigerators revealed: *Temperatures in residents' personal refrigerators were not being monitored or documented. *Staff previously monitored the temperatures of the personal refrigerators and documented them on paper but had stopped "quite a while ago."	F 813		

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F 813	Continued From page 44 Interview on 5/20/25 at 2:20 p.m. with food service supervisor E revealed the dietary staff was not responsible for the food or refrigerators in the residents' rooms. An additional interview on 5/21/25 at 8:44 a.m. with FSS E revealed: *She was responsible for the dietary department. *She was not a certified dietary manager (CDM), but stated social service designee (SSD) D was the provider's CDM. *She stated that the two-page 2018 Food Brought in from an Outside Source policy was their current policy and that she had received the policy from their consultant dietitian. *She was aware of the provider's June 2020 Refrigerator Policy. *She stated that the dietary department was not responsible for the residents' personal refrigerators. Interview and policy review on 5/21/25 at 8:55 a.m. with SSD D revealed she: *Was the assistant administrator, responsible for the social services department, and had a 3/17/25 certificate as a CDM. *Stated that during the residents admissions process, residents and family members would ask about personal refrigerators. *Was a resource to FSS E, who was responsible for the provider's dietary department. *Stated the dietary department was responsible for monitoring and recording the temperatures for the refrigerators in the kitchen. *Agreed that the two-page 2018 Food Brought in from an Outside Source policy was their current policy and that she had reviewed it. -She agreed that the staff were not checking food	F 813		

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F 813	Continued From page 45 or beverages brought into the facility for resident consumption before being accepted for storage as the policy stated. -She agreed that the staff were not labeling "Food or beverages brought in from the outside ... with the resident's name, room number and ... the current date the item(s) are brought into the facility for storage." -She agreed that staff were not monitoring "All cooked or prepared food brought in for a resident and stored in the ... personal room refrigerator will be ... discarded after 72 hours/3 days." -She agreed that the staff were not following the policy regarding "No home-prepared food items that are canned or preserved will be permitted." *Was not aware of the provider's June 2020 Refrigerator Policy and stated it was the first time she had seen that policy. *Had listed the personal refrigerators on each residents' Inventory of Personal Effects form *Thought there were six or seven residents with personal refrigerators in their rooms, but she had not compiled a list of that. *Stated that DON B and the nursing department assisted with monitoring the temperatures of the residents' personal refrigerators. *She had received thermometers last week, which the maintenance staff had placed in the residents' personal refrigerators. Interview on 5/21/25 at 9:37 a.m. with maintenance supervisor G revealed the maintenance staff had checked those personal refrigerators and other electrical appliances (lamps, electric lift chairs, etc.) when family members brought them into the facility. 8. Review of the provider's 2018 Food Brought in from an Outside Source policy revealed:	F 813		

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F 813	Continued From page 46 *"All food or beverages brought into the Community for resident consumption will be checked by a staff member before being accepted for storage. Any suspicious or obviously contaminated food or beverage will be discarded immediately." *"Food or beverages brought in from the outside will be labeled with the resident's name, room number and dated by staff with the current date the item(s) are brought into the facility for storage." *"All cooked or prepared food brought in for a resident and stored in the facilities [facility's] refrigerator or personal room refrigerator will be dated with accepted for storage and discarded after 72 hours/3 days. No home-prepared food items that are canned or preserved will be permitted." Review of the provider's June 2020 Refrigerator policy revealed: *"The refrigerator must be approved by maintenance to meet state code requirements." *"The refrigerator must maintain a safe temperature range of 36-41 degrees Fahrenheit." *"The night nurse will monitor and record the temperature reading every night." *"All food in the refrigerator will be covered. Once the container is opened, it will be dated and removed in an acceptable time frame."	F 813		
F 880 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	F 880	Unable to change the outcome of the deficient practice for resident #4 due to having since passed away. Mechanical lift slings are used for only one resident and are not shared. Slings are to be stored in resident closets when not in use.	7-5-25

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F 880	Continued From page 47 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; §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.	F 880	All slings will be washed according to the manufacturer's instructions weekly and as needed. PPE was placed in hopper room in plastic container mounted on the wall next to hopper. Stocking of hopper rooms will be added to CNA stocking list. The Infection Preventionist and DON have reviewed and updated the Cleaning Reusable Medical Equipment policy and procedures. An all-staff meeting will be held on 6/24/25 to provide education on citation F880, policy and procedure and the requirements to ensure future compliance with this policy. The facility has determined that all have the ability to be affected by this deficiency. Infection Preventionist or designee will audit PPE usage and availability in hopper rooms and proper storage and disinfection of lift slings once per week for four weeks and monthly for two additional months. Infection Preventionist 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.	

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F 880	Continued From page 48 (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, and policy review, the provider failed to follow appropriate infection control practices to ensure: *Shared sit-to-stand mechanical lift slings used for three of three residents who required the sit-to-stand mechanical lift for transfers was properly disinfected between resident use. *Personal protective equipment (PPE) was available in one of one soiled utility rooms to prevent infections and cross-contamination when using the hopper to rinse soiled linens. 1. Observation on 5/19/25 at 8:50 a.m. of the soiled utility room revealed: *There was a hopper (a flushing device used to rinse items and linens soiled with bodily fluids) without a barrier to prevent splash contamination	F 880		

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F 880	Continued From page 49 to staff who cleaned contaminated linen. *No gown or eye protection was available in the soiled utility room to be worn by staff to prevent contamination of staff clothing while they used the hopper to rinse out soiled linens. 2. Interview on 5/20/25 at 10:54 a.m. with CNA N revealed: *Staff used the hopper in the soiled utility room to rinse out soiled linens prior to sending them to laundry. *She stated she had worn a gown previously to rinse out soiled linens in the hopper. *She verified there were no gowns available inside the soiled utility room and she was unable to identify where the closet gowns were available for staff to use when using the hopper. 3. Observation on 5/19/25 at 8:57 a.m. of CNA N as she exited resident 4's room revealed: *Resident 4 had a sign at her room entrance which indicated she was on enhanced barrier precautions (EBP) (required the use of gown and gloves while providing direct personal cares which included transfers). *CNA N wiped down a cloth-covered sling for the sit-to stand lift with a disinfectant wipe. *The sling was not wet immediately after being wiped down with the disinfectant wipe. -Without the sling remaining wet for the indicated contact time of one minute, per manufacturer's instructions, the sling would not be able to be considered disinfected. *CNA N stated the sit-to-stand lift was used for three people, including resident 4, in the facility. 4. Interview on 5/20/25 at 5:14 p.m. with MDS coordinator/infection preventionist (IP) C revealed:	F 880		

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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
F 880	Continued From page 50 *She was aware the sit-to-stand lifts slings were being shared for use for multiple residents and it was her expectation the slings were being wiped with a disinfectant between uses. *She agreed disinfectant cloth wipes would not be effective in disinfecting the sit-to-stand sling due to it being a cloth material. *She was aware there were no goggles or gowns available in the soiled utility room for staff to wear while rinsing soiled linen which posed a risk for splash contamination. *She knew about the splash and water droplet contamination risk that hoppers could cause but had not thought about having PPE or a splash guard for the hopper to protect staff and items in the soiled utility room from contamination. 5. Interview on 5/21/25 at 8:57 a.m. with director of nursing (DON) B revealed: *It was her expectation that staff would wear personal protective equipment (PPE) if there was a risk of splash contamination. *She agreed the hopper would be an area of risk for splash causing contamination while staff used it to rinse soiled items. *She had not thought about a splash guard or PPE availability inside the soiled utility room for staff use to prevent cross contamination. *It was her expectation that items shared between residents be cleaned and disinfected between use to prevent the spread of infection. *She was aware the slings for the sit to stand were being used between residents and it was her expectation the staff was wiping down the slings between each resident. *She agreed the material of the slings would not make it possible for the contact time to be reached with the disinfectant cloths due to the material absorbing the liquid.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 05/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 51 -Without the required disinfectant contact time the sling, shared between residents, would not be considered disinfected for the next resident's use. 6. Review of the provider's January 2025 Cleaning and Disinfecting Reusable Medical Equipment policy revealed: *"The goal is to minimize the risk of infection and cross-contamination by maintaining high standards of hygiene and following best practice in accordance with current infection control guidelines." *"Reusable Medical Equipment: Any equipment or device used on multiple residents that can be cleaned, disinfected, and reused." *"Cleaning: The physical removal of dirt, debris, and bodily fluids from surfaces." *"Disinfection: The process of using chemicals to kill harmful microorganisms on surfaces of reusable medical equipment." *"All reusable medical equipment must be cleaned and disinfected after each use." *"Cleaning and Disinfection Procedure: -Wear appropriate personal protective equipment (PPE). Including gloves, mask, and gowns, as required by infection control protocols."	F 880		
F 940 SS=E	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must	F 940	Unable to change the outcome of the deficient practice for ensuring contracted (agency) staff (O) had completed an effective training program due to contract (agency) staff (O) no longer picking up shifts. An orientation checklist and packet for contracted (agency) has been developed and will be completed for each contracted (agency) staff member.	7-5-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 05/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 940	Continued From page 52 include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to follow their policy and facility assessment to ensure an effective training program for one of two contracted (agency) staff (O). Finding included: 1. Review of the provider's 10/18/2024 Employee Orientation & Ongoing Education policy revealed: *"Purpose: To assure all new employees, current employees, & volunteers receive the education and information required by federal, state, & facility regulations." *"Policy Statements: Orientation Program for All New Employees includes the following:" -"Watching the Mandatory Extravaganza DVDs:" *"Disc 1: Mandatory." -"Safety First." -"Infection Prevention." -"Workplace Environment." --"Resident Rights and Compliance." *"Disc 2: Caregiver." -"Resident Care." -"Caregiver Well-Being." -"Health Conditions." *"Handwashing Demonstration *"Completing additional information as outlined in the New Employee Orientation Checklist." *"Reading and understanding the following documents & policies:" -"Resident's Rights." -"Abuse Prevention and Protection of Resident Rights." -"Ethics and Compliance." -"Notice of Privacy Acts." *"Mandatory annual training for All Personnel	F 940	The Executive Director and DON have reviewed and updated the Employee Orientation & Ongoing Education policy and procedures. The facility has determined that all employees have the ability to be affected by this deficiency. The Executive Director will review all employee files including contracted (agency) employees' files for compliance with this regulation by 7/5/25. BOM or designee will then audit new employee files once per week for four weeks and monthly for two additional months to ensure that new staff are receiving the effective training. The Executive Director 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 05/21/2025

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

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F 940	Continued From page 53 includes the following:" -"Abuse, Neglect, & Misappropriation." -"Accident Prevention & Safety Procedures." -"Corporate Compliance & Ethics." -"Fire, Disaster, & Medical Emergency Preparedness." -"HIPAA & Confidentiality." -"Nutrition, Hydration, & Dining Experience." -"Quality Assurance & Performance Improvement." -"Trauma Informed Care." -"Advanced Directives." -"Care of Residents with Unique Needs." -"Dementia Care." -"Hospice & End of Life Care." -"Infection Control & Disease Prevention." -"Resident Rights." -"Use of Restraints." *"Certified Nursing Assistants will receive an additional 12 hours of education/training determined by our residents' population, unique needs, facility assessment & environment, & staff turnover." 2. Review of certified nursing assistant (CNA) O's education records revealed: *She was hired on 12/14/2024 as a contracted CNA. *Her first scheduled shift to work was on 12/14/2024. *There was no documentation to support that employee O had been trained on all the topics according to the provider's orientation and education policy. 3. Interview on 5/21/25 at 8:16 a.m. with executive director A revealed: *She stated the facility does not have agency staff complete the training topics listed in their policy.	F 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 05/21/2025

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

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F 940	Continued From page 54 *She stated that the contracts received by the agencies were reviewed but the education piece of the contracts was not looked at closely. *Her expectation was for the agency staff's employing company to have had the staff complete the training before the agency staff provided care and services at the facility. *She agreed for the safety of the residents, the agency staff should have had the required training completed according to their policy. 4. Review of the provider's New Employee Orientation Checklist revealed: *"Human Resources Representative and/or Specified Department Manager:" -"Initial each item when completed." --"Schedule Date/Time to Watch Orientation Videos." *"Business/Administrative Manager." -"Ensure Collection and Confirm Completion of All Forms:" --"Employee Orientation and Education Policy." 5. Review of the provider's January 2025 Facility Assessment revealed: *"Individual staff assignment:" -"We staff according to census and acuity. All staff are oriented to both stations and trained to provide continuity of care for all residents. *"Staff training/education and competencies." -"All registered nurses (RNs), licensed practical nurses (LPNs), certified medication aides (CMAs), and certified nursing assistants (CNAs) staff are required to complete new hire orientation. -"Staff with no experience in long-term care will have longer orientation periods." -"Ongoing training/education opportunities are completed initially upon hire and annually."	F 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	C 05/21/2025

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

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F 940	Continued From page 55 -"Staff are assigned to a team leader to train and assist them with resident activities of daily living (ADLs)." *"Training Topics: (this is not an inclusive list):" -"Communication," -"Resident's rights and facility responsibilities," -"Abuse, neglect, and exploitation," -"Infection Control," -"Culture change," -"Identification of resident changes in condition," -"Cultural competency," -"Person-centered care planning, education of staff and family," -"Activities of daily living," -"Disaster planning and procedures," -"Medication administration," -"Measurements," -"Resident assessment and examinations," -"Caring for persons with Alzheimer's or other dementia," -"Specialized care," -"Caring for residents with mental and psychosocial disorders, trauma or post-traumatic stress disorder," *"Policies and procedures for provision of care." -"Our policies and procedures then would be updated to reflect the new requirements to ensure we are meeting the current professional standards of practice."	F 940		

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 _____	05/21/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/18/25 through 5/21/25. Sun Dial Manor was found in compliance.	S 000		
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 5/18/25 through 5/21/25. Sun Dial Manor was found not in compliance with the following requirements: S210.	S 000		
S 210	44:73:04:06 Personnel Health Program The facility shall have a personnel health program for the protection of the residents. Before assignment to duties or within fourteen days after employment, a licensed health professional must evaluate all personnel to ensure no personnel is infected with any reportable communicable disease that poses a threat to others. The evaluation must include an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease that may endanger the health of residents, and fellow personnel may not return to duty until the personnel is determined by a physician, physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a	S 210	Unable to change the outcome of the deficient practice for ensuring contracted (agency) staff (O) had a required health evaluation completed and signed by a licensed health professional within 14 days of her hire date. An orientation checklist and packet for contracted (agency) has been developed and will be completed for each contracted (agency) staff member. The executive director (ED) and DON have reviewed and updated policies and procedures for health evaluations for staff, including contracted staff. The facility has determined that all employees have the ability to be affected by this deficiency. The ED or designee will review all employee files, including contract (agency) employees' files for compliance with this regulation. The ED or designee will then audit all new employee files once per week for four weeks, and monthly for two additional months. The ED or designee will present findings from audits at the monthly QAPI committee meeting and continue audits until the facility demonstrates sustained compliance as determined by the QAPI committee.	7-5-25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Voss — TITLE: Executive Director — (X6) DATE: 6-20-25

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 _____	05/21/2025

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 210	Continued From page 1 communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of two contracted (agency) staff (O) had a required health evaluation completed and signed by a licensed health professional within 14 days of her hire date. Findings included: 1. Review of certified nursing assistant (CNA) O's employee records revealed: *She was hired on 12/14/24. *There was no documentation that a health evaluation had been completed by a licensed health professional. 2. Interview on 5/21/25 at 8:16 a.m. with executive director A revealed: *Her expectations were for the agency staff's employing company to required health evaluation completed and signed by a licensed health professional before providing services to the residents. *She agreed for the safety of the residents, the agency staff members should have the required health evaluation completed and signed by a licensed health professional within 14 days of their hire date.	S 210		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING _____ B. WING _____	05/20/2025

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

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E 000	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 5/20/25. Sun Dial Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Voss — TITLE: Administrator — (X6) DATE: 6-13-2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435093	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/20/2025**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey was conducted on 5/20/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sun Dial Manor was found in compliance.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Voss — TITLE: Administrator — (X6) DATE: 6-13-2025

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.