| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435093 | A. BUILDING _____ B. WING _____ | C 12/21/2023 |

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| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/18/23 through 12/21/23. Sun Dial Manor was found not in compliance with the following requirements: F578, F609, F679, F684, F726, F727, and F761.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 12/18/23 through 12/21/23. Areas surveyed included falls and quality of care. Sun Dial Manor was found not in compliance with the following requirements: F609 and F684. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. | F 578 | •Code status treatment option forms completed for residents 10 and 12.<br>•Administrator, DON, Social Services Director, and Interdisciplinary Team will review and revise as necessary the policy and procedure on advance directives.<br>•All other residents can be affected by this deficient practice. Code status treatment option forms for all other residents were audited to ensure a code status was designated by the resident and/or their representative.<br>•DON or designee will provide education to all staff responsible for following advance directives appropriately on 01/22/2024.<br>•Social Services Director or designee will perform audits weekly for four weeks and monthly for two additional months.<br>•Social Services Director or designee will present findings at the monthly QAPI meetings. | 1/23/24 |

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

Clay Brouwer | Administrator | 01/17/2024

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 578 | Continued From page 1 | F 578 | | |

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to ensure a code status (individual desire to resuscitated Full Code with cardiopulmonary (CPR) versus not resuscitated if their heart stopped Do no resuscitate (DNR)) was designated by the resident and/or their representative for two of two sampled residents (10 and 20). Findings include:

1. Review of resident 10's electronic and paper medical record revealed:
*She had a durable power of attorney (DPOA) assignment document.
*A copy of her 5/31/22 physician's order summary report from the nursing home provider she was transferred from indicated a do not resuscitate (DNR).

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| F 578 | Continued From page 2<br>*That physician's order was changed to cardiac pulmonary resuscitation (CPR) upon admission.<br>*There was no documentation that resident 10 or her representative had changed her wishes for her code status from the previous nursing home.<br><br>2. Review of resident 12's electronic and paper medical record revealed:<br>*There was a DPOA who was her son.<br>*There was no documentation regarding resident 12 or her DPOA choice of a DNR designation.<br><br>Interview on 12/20/23 at 10:30 a.m. with social services designee G revealed:<br>*A code status treatment option form was to have been completed when a resident was admitted to the facility.<br>*The treatment option form was given to the resident and/or representative. If a DNR was requested a physician's order was required.<br>*All resident's code status' were reviewed during their quarterly care conferences.<br>*She was not aware residents 10 and 12 had no code status option form completed.<br><br>Review of the provider's revised 1/2/23 Advance Directives policy revealed:<br>*Advance directives were defined as preferences regarding treatment options and included, but were not limited to:<br>-"Do Not Resuscitate - Indicates that, in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy, or representative (sponsor) have directive that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used."<br>*Changes to or removals of an advance directive should have been submitted to the administrator.<br>*The director of nursing services would then | F 578 | | |

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| F 578 | Continued From page 3<br>notify the attending physician of the resident's advance directive. The attending physician would be responsible for issuing appropriate orders that would coincide with the resident's advance directive. | F 578 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by: | F 609 | •Unable to change the outcome of the deficient practice for reporting and investigating resident 8's fall.<br>•Administrator, DON, and Interdisciplinary Team will review and revise as necessary the policies and procedures for reporting falls and alleged violations.<br>•All other residents can be affected by this deficient practice.<br>•All other residents with falls since 12/21/2023 will be audited to ensure investigation and reporting to the SDDOH if necessary.<br>•DON or designee will provide education and training to all licensed staff responsible for assessing and determining care needs. Licensed staff will be trained on completing a thorough and accurately document assessment of resident(s) after a fall or event that includes ongoing assessment for changes in condition or pain so that they may be followed up by the appropriate provider. Training will include reporting events that are required by Federal and State regulations. Unlicensed staff will be trained on processes for reporting resident falls and other events requiring further assessment and potential reporting on 01/22/2024. | 1/23/24 |

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| F 609 | Continued From page 4<br>Based on interview, record review, and policy review the provider failed to ensure one of one sampled resident (8) who had a fall with a fracture and transported to an acute care facility was thoroughly investigated and reported to the South Dakota Department of Health (SDDOH). Findings include:<br><br>1. Review of resident 8's electronic medical record (EMR) revealed:<br>*She had a witnessed fall on 8/30/23 at 7:07 a.m.<br>*She was seen by the physician nine days after the fall on 9/8/23 and an x-ray revealed a left pelvic fracture.<br>*There was no documentation in the EMR that the fall had been investigated or reported to the SDDOH.<br><br>Interview on 12/21/23 at 12:10 p.m. with administrator A revealed:<br>*He was aware she had fallen but he was not aware of the pelvic fracture.<br>*He agreed it should have been investigated and reported by the previous director of nursing (DON) to the SDDOH.<br>*The DON was responsible to investigate all incidents.<br>*The DON is responsible to report incidents that met the criteria to the SDDOH as applicable.<br>*The DON employed at that time was no longer employed.<br><br>Review of the providers undated Fall Prevention Program policy revealed the charge nurse would complete the required healthcare facility event reporting form from the SDDOH and to the local ombudsman.<br>*The nurse initiating the investigation is responsible for the following through with the | F 609 | •DON or designee will audit all incident reports to ensure proper reporting has been completed by the charge nurse weekly for four weeks and monthly for two additional months.<br>•DON or designee will present findings from these audits at the monthly QAPI meetings. | |

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| F 609 | Continued From page 5<br>investigation process and completed the final report within 5 days. All documentation and investigation interviews will be documented on the event reporting form.<br>*Any major incident, event, injury, or any injury of an unknown origin will be reported immediately to the administrator and director of nursing. | F 609 | | |
| F 679 SS=E | Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, record review, and policy review, the provider failed to ensure the activity coordinator had the ability to develop, implement, supervise, and evaluate a one-to-one activities program for four of four sampled residents (10, 12, 13 and 19) at risk for social isolation. Findings include:<br><br>1. Random observations of resident 10 on 12/19/23 from 8:00 a.m. through 5:00 p.m., on 12/20/23 from 8:00 a.m. through 5:00 p.m. and on 12/21/23 from 9:00 a.m. through 10:30 a.m. revealed:<br>*Observations on:<br>-12/19/23 from 8:00 a.m. through 11:50 a.m. she | F 679 | •Unable to meet the requirement for having a qualified activity coordinator by designated date due to length of course.<br>•Employee (i) was registered into the state approved activity coordinator training program on 06/05/2023 to become a licensed activity professional within the facility.<br>•Administrator, DON, Activities Coordinator, and Interdisciplinary Team will review and revise as necessary the policy and procedure for developing and implementing a one-to-one activities program for residents 10, 12, 13, and 19.<br>•All residents have the potential to be affected by this deficient practice.<br>•All other residents needing one-to-one activities will be audited to ensure implementation of the one-to-one program.<br>•Activities Coordinator or designee will audit one-to-one activity care plans and assessments for completion once a week for four weeks and monthly for two additional months.<br>•Activities Coordinator or designee will present findings from these audits at the monthly QAPI meetings. | 1/23/24 |

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had been assisted out of her bed and into her recliner about 9:30 a.m. She was stayed sitting in her recliner the rest of the morning. During the above time the lights were off in her room and she had her eyes closed. She had a television and a talking book player in her room.
-12/19/23 at 2:30 p.m. she was still seated in her recliner. The lights were on and her roommate was in the room seated in her recliner. They both had their eyes closed.
-12/19/23 at 5:00 p.m. she was in her bed with the lights off. Her eyes were closed.
-12/20/23 at 8:30 a.m. she had been assisted into her recliner. She was eating her breakfast.
-12/20/23 at 10:30 a.m. she was still seated in her recliner with her eyes closed. The lights were off in her room.
-12/20/23 at 4:00 p.m. she was lying in her bed. There were a group of children singing Christmas carols in the hall outside of her room.
-12/21/23 at 9:00 a.m. she was lying in her bed with her eyes closed. The lights were off in her room.
-12/21/23 at 10:30 a.m. she was seated in her recliner with her eyes closed. The lights were off in her room.

Observation and interview on 12/19/23 at 8:14 a.m. with certified nursing assistant K during and after she had provided personal care and assisted resident 10 from her bed to her recliner revealed:
*CNA K only provided information with resident 10 during her personal cares and transfer on what she need to help with or with what was next.
*CNA K did not engage resident 10 in any other conversation.
*Resident 10 did not like to come out of her room at all. She also does not like to get out of her bed

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| F 679 | Continued From page 7<br>many times.<br>*There was a television and and talking book reader in her room. Neither of those items were offered to be turned on.<br><br>Review of resident 10's electronic medical record (EMR) revealed:<br>*A 2/14/23 activity assessment. That assessment revealed she:<br>-Participated in one to two activities a week.<br>-Did not like to participate in group activities.<br>-Participated in one-to-one activities.<br>-Required assistance to attend activities.<br>-Preferred to stay in her room and be alone. Will visit with family and friends.<br>-Was blind.<br>*A 11/8/23 activity participation progress note indicated she did not come out for group activities and preferred to stay in her room. She enjoyed word games, trivia, conversing, and nail care. One-to-one visits as the were able during the week, usually three to four times a week.<br><br>Review of resident 10's 8/23/22 activity care plan revealed:<br>*Need: "I am dependent on staff for meeting emotional, intellectual, physical, and social needs d/t [due to] my blindness, inability to walk, feeling tired/having little energy, feeling depressed and sleeping too much."<br>*Goals: "I will attend/participate in activities of choice by next review date."<br>-"I will maintain involvement in cognitive stimulation, social activities as desired through review date."<br>*Supports: "All staff please converse with me while providing care and entering my room."<br>-"Honor my choice not to attend activities as I so choose." | F 679 | | |

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| F 679 | Continued From page 8<br>-"I will participate in talking books and the Activity Director will assist me with receiving books from the SD [South Dakota] State Library. Staff will assist me in turning the talking book player on/off."<br>-"Invite and assist me to scheduled activities per my interests and choices. However, I choose not to participate in group activities and I prefer to stay in my room; generally in bed."<br>-"I will receive 1-1 visits for added stimulation and interaction."<br>-"Offer and assist me with turning my TV on. I do like to listen to the music channels at times."<br><br>2. Review of resident 12's EMR revealed:<br>*A 3/6/23 activity assessment. That assessment revealed he:<br>-Participated in three-to-five activities a week.<br>-Chose not to participate in group activities.<br>-Participated in one-to-one activities.<br>-Required assistance to attend activities.<br>-Was a passive participant in activities.<br>-Rarely initiated conversations.<br>-Preferred to be out of his room.<br>-Preferred to be with people.<br>-Ambulated with an assistive device.<br>-Had a short attention span.<br>*Activity participation notes since his 3/6/23 activity assessment revealed:<br>-On 5/31/23 "In the past seven days. [Resident] has not participated in any activities in the activity room. He has been in the sunroom on occasion and hardly participates in the small group reminiscing activity. He will read something when prompted and watches TV."<br>-A activity note on 10/3/23 included:<br>--"Due to [Resident} decline in health and difficulty speaking we try to stimulate him with balloon/ball toss, reality orientation pictures, pet visits, picture | F 679 | | |

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| F 679 | Continued From page 9<br>books, and we converse with him."<br>--"He spends the majority of his time in his room or the Sun Room sleeping, interacting and people watching with residents, visitors, and staff."<br>-On 12/16/23 "[Resident] attends very limited activities due to his declining health and inability to speak...We are working on a schedule of 1:1 activities for [resident] that could include: ball toss, picture orientation, and fidget sensory activities."<br><br>Review of resident 12's last updated 12/18/23 care plan revealed no area for activities were identified.<br><br>3. Review of resident 13's EMR revealed:<br>*She was admitted on 8/29/23.<br>*There was no activity assessment located in the EMR.<br>*A 11/24/23 activity participation note: "[Resident] refuses to come out of her room for activities. But we continue to invite her....She is content to stay in her room and has an iPad that she uses to communicate with family & friends. She also plays cards on it."<br><br>Review of resident 13's 9/12/23 care plan revealed no area for activities were identified.<br><br>4. Review of resident 19's EMR revealed:<br>*He was admitted on 4/12/23.<br>*An activity admission assessment was completed on 4/25/23 revealed:<br>-He had current interests that included spending time outdoors, watching TV, and conversing with others.<br>-For the question of when he preferred to participate in scheduled activities his answer was none. | F 679 | | |

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| F 679 | Continued From page 10<br><br>Review of resident 13's revised 10/10/23 care plan revealed:<br>*Need: "The resident has little or no activity involvement r/t [related to] onset of Lewy Body disease [a form of dementia]."<br>*Goal: "The resident will participate in activities of choice three times per week."<br>*Supports: "Explain to the resident the importance of social interaction, leisure activity time. Encourage the resident's participation by (SPECIFY)." The rest of this support had not been completed.<br>-"Remind the resident that the resident may leave activities at any time, and is not required to stay for the entire activity."<br>-"The resident needs assistance/escort to activity functions."<br><br>Interview on 12/20/23 at 3:52 p.m. with activity coordinator I revealed she:<br>*Had started in May 2023 and was currently working full-time.<br>*Was in the process of completing the activity coordinator classes.<br>*Was in the process of completing her nursing assistant certification.<br>*Had not completed any activity needs assessments for the residents.<br>*Was not sure how to revise or change a resident's care plan.<br>*Had not completed any one-to-one activity assessments.<br>*Did not think section F on the Minimum Data Set (MDS) was helped provide activities for resident interests and preferences.<br>*Had not updated any care plans.<br>*Did not document in the EMR.<br>*Had some documentation in her book. | F 679 | | |

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| F 679 | Continued From page 11<br>*Had a activity consultant to assist her with the completion of assessments for the residents.<br>*Had not completed any specific training with the previous activity coordinator.<br>*Had not worked with the MDS coordinator to work on care plans. The MDS coordinator had just started in November 2023.<br>*Did not have any assistance to organize the activity program.<br>*Had a activity assistant who worked full-time.<br>*Had a volunteer that assisted with activities Monday through Thursday from 9:30 a.m. to 3:00 p.m. for both the nursing home and the assisted living residents.<br><br>Review of the provider's revised 1/2/23 1-1 Programming Policy revealed:<br>*"The 1-1 programming is designated for the following resident: 1) the bed fast resident; 2) the resident in isolation; 3) the resident with severe communication problems; 4) the resident who appears unable to cooperate in any group activity and 5) the resident who is severely withdrawn and depressed."<br>*"Each 1-1 program must work on a goal in each contact. Each contact should be at least 15 minutes."<br>*"All approaches should be based on known interests, lifestyles, and habits."<br>*"When charting 1-1 programming; the program, resident response and length of time spent with resident must be charted."<br>*"Individualized 1-1 programming must be care planned." | F 679 | | |
| F 684 SS=G | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care | F 684 | •Unable to change the outcome of the deficient practice for reporting resident 8's fall to the SDDOH, and for providing appropriate and necessary care during the nine days following the fall. | 1/23/24 |

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| F 684 | Continued From page 12<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on South Dakota Department of Health (SDDOH) report review, record review and interview, the provider failed to ensure one of one sampled resident (8) had received appropriate and necessary care and treatment for nine days after a witnessed fall in her bathroom. Findings include:<br><br>1. Review of resident 8's medical records revealed:<br>*On 8/30/23 at 7:07 a.m. included:<br>-Resident 8 had a witnessed fall in the bathroom while a certified nursing assistant (CNA) was doing morning cares.<br>-Range of motion was intact, but resident winced with moving the left leg and she would hold on to her left hip.<br>- Resident 8 was unable to give description and could not describe her pain level.<br>-Resident was assisted to a standing position and was helped to her recliner with extensive assist of two staff.<br>*On 8/30/23 at 8:30 a.m. she received acetaminophen 325 milligram (mg) two tablets for pain.<br>*Her physician had been notified on 8/30/23 at 10:30 a.m. by facsimile of her above fall and complaints of left hip pain. Orders had been received at 11:33 a.m. "If pain persist she should | F 684 | •Administrator, DON, and Interdisciplinary Team will review and revise as necessary the policies and procedures for reporting falls, and for providing necessary care and treatment of residents on 01/22/2024.<br>•All other residents can be affected by this deficient practice.<br>•All other residents with falls since 12/21/2023 will be audited to ensure investigation and reporting to the SDDOH if necessary.<br>•Unable to educate CAN H due to no longer being employed at the facility.<br>•DON or designee will provide education and training to all licensed and unlicensed staff responsible for providing quality care and reporting falls. Medication aides and licensed nurses will be retrained on charting administered medication. Licensed staff will be trained to follow physician orders immediately if pain is recognized by staff following a resident fall. Training will be completed on 01/22/2024.<br>•DON or designee will audit all incident reports to ensure proper reporting has been completed by the charge nurse weekly for four weeks and monthly for two additional months.<br>•DON or designee will present findings from these audits at the monthly QAPI meetings. | |

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| F 684 | Continued From page 13<br>be seen as she may have a pelvic fracture."<br>-This had been noted by two registered nurses (RN). One of which was RN D.<br>*On 8/30/23 at 9:20 p.m.:<br>-She had refused to walk and used the wheelchair for transportation for that evening shift.<br>-She grabbed at her hips and thighs when she attempted to walk.<br>*On 9/1/23 at 10:18 a.m.:<br>-She continued to require extensive assistance of one to two staff for transfers and toileting.<br>-She was afraid of falling when she attempted to stand.<br>-She used the wheelchair exclusively for transportation.<br>*On 9/1/23 at 2:07 p.m. she became easily annoyed at times.<br>*On 9/8/23 at 8:34 a.m. request was received from her power of attorney to make an appointment to see her physician as she was still not ambulating nine days after her fall.<br>*On 9/8/23 orders from certified nurse practitioner had included:<br>-May do physical therapy three times a week for 6 weeks.<br>-Give scheduled Tylenol extended release one tab every 8 hours.<br>-May also give as needed Tylenol of no more than 3500 mg in 24 hours.<br>-May give tramadol 50 mg every 6 hours as needed for severe pain.<br><br>Review of a 9/8/23 radiology report revealed resident 8 had an acute mildly displaced fracture of the left superior pubic ramus (pelvic fracture).<br><br>Review of resident 8's medication administration record (MAR) revealed: | F 684 | | |

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| F 684 | Continued From page 14<br>*On 8/30/23 at 8:31 a.m. resident 8's pain was rated three out ten per the Pain Assessment In Advanced Dementia (PAINAD) Scale and she received acetaminophen 325 mg two tablets.<br>*She did not receive any other pain medication until 9/7/23 at 10:04 a.m. which was acetaminophen 325 mg two tablets for a pain rating of one out of ten.<br><br>Review of the PAINAD scale scored by a zero, one, or two in the categories of:<br>*"Breathing (occasional laboured breathing, Short Period of hyperventilation [fast breathing]).<br>*Negative vocalization (Occasional moan or groan, Low level of speech with a negative quality).<br>*Facial expression (Sad, frightened, frown).<br>*Body language(relaxed).<br>*Consolability (No need to Console)."<br><br>Review of resident 8's pain level summary revealed:<br>*On 8/30/23 at 7:02 a.m. resident 8 scored a one in each category with total score of 5.<br>*On 8/30/23 at 8:31 a.m. she scored a one in breathing, negative vocalization, and facial expression with total score of three.<br>*On 9/10/23 at 7:53 a.m. she scored a zero.<br>*On 9/10/23 at 11:58 a.m. she scored a one in negative vocalization, facial expression, body language, and consolability with a total score of four.<br><br>Interview on 12/21/23 at 9:35 a.m. with certified nursing assistant/medication aide (CNA/MA) regarding resident 8's fall on 8/30/23 revealed:<br>*She did not remember if she worked that day but did remember that resident 8 had fallen.<br>*She had complained of pain after the fall when | F 684 | | |

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| F 684 | Continued From page 15<br>she sat in her wheelchair or when she attempted to stand up.<br>*She stated she had given her Tylenol when she had pain.<br>*Review of the September 2023 MAR revealed no documentation she had given Tylenol to resident 8.<br><br>Interview on 12/21/23 at 9:40 a.m. with CNA H regarding resident 8's fall revealed:<br>*She does not remember if she worked the day of the fall but did remember resident 8 had fallen.<br>*She was in her wheelchair and would complain of pain and she reported it to her nurse and they would give pain medication.<br>*She was up and walking shortly after the fall.<br>*She didn't remember if she worked with therapies.<br><br>Interview on 12/21/23 at 9:48 a.m. with RN D revealed:<br>*Resident 8 was initially okay the first couple of days after her fall and was up and about.<br>*She did have pain with transfers with standing-to-sitting and sitting-to-standing.<br>*She did have Tylenol and maybe as needed tramadol for a little bit.<br>*She has two daughters, one is the power of attorney (POA) and another daughter whom visits frequently.<br>*She said resident 8 had fallen prior with the same symptoms with no issues and the staff wanted to see if she recovered as she had before because in the prior fall, family had wanted to wait to see how she did.<br><br>Interview on 12/21/23 at 12:10 p.m. with administrator A revealed:<br>*He was aware she had fallen but he was not | F 684 | | |

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| F 684 | Continued From page 16<br>aware of the pelvic fracture.<br>*He agreed it should have been reported to the SDDOH.<br>*The director of nursing (DON) was responsible to investigate all incidents.<br>*The DON is responsible to report incidents that met the criteria to the SDDOH as applicable.<br>*The DON employed at that time was no longer employed. | F 684 | | |
| F 726 SS=F | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able | F 726 | •Administrator, DON, and Interdisciplinary Team reviewed and revised the training requirements to include UAPs and licensed nurses, and competencies to be completed before working with residents.<br>•Training nurse will be responsible for completing CNA competencies before the individual can work with residents and annually thereafter.<br>•DON will be responsible for completing UAP and licensed nurse competencies before the individual can work with residents and annually thereafter.<br>•All nursing staff files will be audited for competency evaluations and completed as necessary.<br>•DON or designee will audit all new hire files for competency and skill set completions weekly for four weeks and monthly for two additional months.<br>•DON or designee will present findings at the monthly QAPI meetings. | 1/23/24 |

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| F 726 | Continued From page 17 | F 726 | | |

to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:
Based on interview, and policy review, the provider failed to ensure all licensed nursing staff [registered nurses (RNs) and licensed practical nurses (LPNs)], unlicensed assistive personnel (UAPs), and certified nursing assistants (CNAs) completed competency evaluations prior to working with residents, and annually.
Findings include:

1. Interview on 12/19/23 at 1:00 p.m. with registered nurse RN D and RN E regarding competencies for the RNs and LPNs, UAPs, and CNAs revealed:
*A new director of nursing (DON) B had started working approximately one month ago. She asked RN D to put together a competency plan for the CNAs to use in learning and maintaining skills necessary to provide care to the residents.
*RN D:
-Had been working on the skill sets and they would be completed soon.
-Stated the CNAs had not completed any competencies since before the pandemic in 2020.
-Was not aware that the competencies were supposed to have occurred before working with residents.
*When asked about UAPs receiving medication competencies annually RN D stated she:
-She had no part in training the UAPs.
-Had not seen any UAP competencies completed since before the pandemic.
-Was making a plan for developing a UAP competency skills.

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| F 726 | Continued From page 18<br>*When RN D was questioned about any recent nurse competencies she stated the most recent licensed nurse was at the beginning of the pandemic.<br>-That competency was for hand washing.<br>*RN D stated there were no competencies available for use.<br><br>2. Interview on 12/21/23 at 1:00 p.m. with DON B regarding the use of competencies revealed she confirmed the nursing staff, including CNAs and UAPs had not been receiving any competency education.<br><br>3. Review of the provider's 5/9/22 Training Requirements for Nursing Assistants revealed the DON or delegated experienced person would have a CNA demonstrate at least five skills and the observer would determine if the demonstration was pass or fail. If the CNA did not meet performance standards, additional education would have been provided and the CNA would demonstrate the skill until performance standards were met.<br><br>There was no documentation in the above training requirements policy for UAPs or licensed nurses. | F 726 | | |
| F 727 SS=E | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under | F 727 | •RNs scheduled for 8 Hrs. a day, 7 days a week.<br>•Administrator or designee will audit the nursing schedule and payroll records to ensure 8 Hrs. of RN coverage daily.<br>•Education was provided to Business Manager and DON to ensure a registered nurse is scheduled for eight consecutive hours. | 1/23/24 |

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| F 727 | Continued From page 19<br>paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.<br><br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:<br>Based on interview, staff schedule review, and payroll record review, the provider failed to ensure a registered nurse (RN) was scheduled for eight consecutive hours for multiple shifts from April 2023 through August 2023. Findings include:<br><br>1. Interview and staff schedule review on 12/20/23 at 10:42 a.m. with administrator A regarding RN coverage revealed he:<br>*Had been aware they did not have eight hours of RN coverage seven days per week.<br>*Stated they always had a nurse in the building, but not always an RN on weekends.<br>*Thought there was a document for a certain number of days that waived RN coverage for eight hours per day.<br><br>2. Interview, staff schedule review, and payroll record review on 12/20/23 at 2:33 p.m. with administrator A and business manager C revealed:<br>*Business manager C was responsible for filing the payroll-based journal (PBJ) reports.<br>*Business manager C was aware they had not provided eight hours of RN coverage seven days per week.<br>*Payroll records and staff schedule comparisons confirmed no RN coverage for the following:<br>-One of five Sundays in April. | F 727 | •Administrator or designee will audit the nursing schedule and payroll records weekly for four weeks and monthly for two additional months.<br>•Administrator or designee will present findings at the monthly QAPI meetings. | |

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| F 727 | Continued From page 20<br>-Two of four Saturdays in May.<br>-Three of four Sundays in May.<br>-One of five Mondays in May.<br>-One of five weekends in July.<br>-One of four weekends in August.<br>*Administrator A had taken over the nursing schedule a couple of months ago from the former director of nursing.<br>*It was administrator A's expectation to have met the federal requirements for RN coverage. | F 727 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. | F 761 | •Secure double locked system for storing medications awaiting destruction created.<br>•Administrator, DON, and Interdisciplinary Team reviewed and revised as necessary the storage of controlled drugs policy and added the process for counting controlled drugs awaiting destruction.<br>•DON or designee will train and educate RN D and other licensed nurses on the revised storage of controlled drugs policy, and the process for counting controlled drugs awaiting destruction on 01/22/2024.<br>•Resident 6 and other resident medication awaiting destruction that was stored in the locked cupboards has been destroyed.<br>•Medication awaiting destruction will be stored in the locked medication room in the locked cupboards.<br>•Medication awaiting destruction will have disposition documentation attached to the card which includes the count, resident name, strength, and dose.<br>•Controlled medication awaiting destruction will be counted between nursing staff shifts if it is not destroyed. | 1/23/24 |

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| F 761 | Continued From page 21<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and policy review, the provider failed to have a secure system for storing medications that were awaiting destruction in one of one medication storage cupboard.<br>Findings include:<br><br>1. Observation on 12/20/23 at 3:30 p.m. of the medication carts, medication room and the cupboards adjacent to the long-term care medication room revealed:<br>*There was a locked cupboard outside of the medication room.<br>-When registered nurse (RN) D was asked about the cupboard she stated it was used to store resident medications that were awaiting destruction.<br><br>Observation of the contents of the cupboard included eight blister pack cards that had the following medications:<br>*Five of those resident blister pack cards contained non-narcotic medications.<br>*Three of the eight cards contained schedule IV controlled medication (considered high risk for drug diversion).<br>*Resident 28 had one card of nineteen tablets of Alprazolam 0.25 milligram.<br>-Eleven tablets had been removed.<br>*Resident 6 had two cards of Tramadol HCL 50 mg:<br>-One card contained eighteen tablets.<br>--Twelve tablets had been removed.<br>-The second card contained nineteen tablets.<br>--Eleven tablets had been removed.<br><br>Interview with RN D regarding the security of the | F 761 | •Each licensed nurse on duty will have a key to the locked medication room and cupboards.<br>•DON or designee will audit disposition documentation once a week for four weeks and monthly for two additional months.<br>•DON or designee will present findings at monthly QAPI meetings. | |

| 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 12/21/2023 |

| 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 761 | Continued From page 22<br>medication cupboard revealed:<br>*The cupboard was affixed to the wall.<br>*There was only one lock on the cupboard door.<br>*No locks were used inside the cupboard.<br>*All medications stored for destruction were removed from the medication carts and medication rooms and placed in the cupboard, including controlled substances.<br>*The above blister seal cards had no disposition documentation attached to the card to identify how many tablets were in the card when it was placed in the cupboard.<br>*The medications placed in the cupboard, including the controlled drugs were not being counted after they were placed in the cupboard.<br>*RN D stated there were three keys to the cupboard; Each nurse on duty carried a key while working. The director of nursing also had a key.<br>*RN D confirmed:<br>-The cupboard should have been double-locked if controlled medications were being stored in the cupboard.<br>-There should have been complete documentation of the medication count when the medication was placed in the cupboard for destruction.<br>-The controlled medication in the cupboard was not being counted by the nursing staff between shifts.<br><br>Interview on 12/21/23 at 12:30 p.m. with DON B confirmed the controlled medication had not been stored securely.<br><br>Review of the provider's 6/20/20 Storage of Medications revealed all controlled drugs were to have been stored under double-lock and key. | F 761 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| 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 _____ | 12/21/2023 |

| 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<br><br>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 from 12/18/23 through 12/21/23. Sun Dial Manor was found in compliance. | E 000 | | |

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

Clay Brouwer | Administrator | 1/9/2024

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| 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<br>B. WING _____ | 12/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SUN DIAL MANOR | 410 SECOND STREET<br>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<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 12/20/23. Sun Dial Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. | K 000 | | |

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

Clay Brouwer | Administrator | 1/9/2024

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.

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 _____ | 12/21/2023 |

| 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<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/18/23 through 12/21/23. Sun Dial Manor was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Clay Brouwer — TITLE: Administrator — (X6) DATE: 1/9/2024