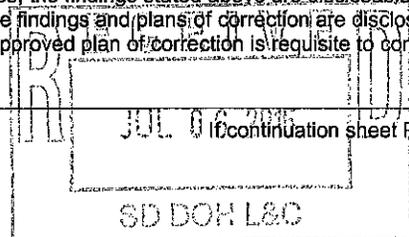


STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUN DIAL MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219</b>	
(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  Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/18/15 through 5/20/15. Sun Dial Manor was found not in compliance with the following requirement(s): F371, F372, and F431.	F 000		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Kitchen cupboards and shelves had been kept clean to prevent possible cross-contamination (bacteria moving from one area to another area) to the resident's food. *Outdated food items had been removed from the walk-in refrigerator. Findings include:  1. Observation on 5/18/15 at 4:30 p.m. and random observations from 5/19/15 to 5/20/15 of the kitchen food preparation area revealed:	F 371	The Consultant RD will provide a mandatory Dietary in-service for education on the updated policy and procedures about ensuring sanitary conditions are maintained for food storage and food is maintained and/or used per policy or manufacturer's recommendations on Tuesday, June 16, 2015.  The outer doors of the kitchen cupboards were cleaned by the Dietary Manager on 5/19/15 and the ceiling vent was cleaned by one of our cooks on 6/10/15.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Peggy L. Pearson TITLE Administrator (X6) DATE 07-02-15

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:  <b>435093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUN DIAL MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219</b>		
(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 371	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>*Grime and dried on matter on multiple outer doors on kitchen cupboards.</li> <li>*Crumbs of food on the bottom shelves.</li> <li>*A vent on the ceiling heating unit covered with grime that was located next to the stove.</li> </ul> <p>Review of the provider's May 2015 Monthly Dietary Cleaning Checklist for the kitchen revealed:</p> <ul style="list-style-type: none"> <li>*Cleaning was to have been done by the dietary staff.</li> <li>*Gaps in the checklist including cleaning of the areas mentioned above showed cleaning had not been done.</li> <li>*Those areas should have been cleaned weekly.</li> </ul> <p>Review of the provider's January 2012 Kitchen Cleaning policy revealed:</p> <ul style="list-style-type: none"> <li>**"All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks, and chipped areas."</li> <li>**"Items in the kitchen will be cleaned in accordance with the monthly cleaning schedule."</li> <li>**"All cooks and aides are responsible for cleaning in the kitchen."</li> </ul> <p>2. Observation on 5/18/15 at 4:30 p.m. of the walk-in refrigerator in the kitchen revealed:</p> <ul style="list-style-type: none"> <li>*A jug of tartar sauce with an outdate of 3/11/15.</li> <li>*A jug of salsa that had been opened "10/20."</li> <li>*A container of cottage cheese with an outdate of 4/30/15.</li> <li>*A carton of half and half cream with an outdate of 5/9/2015.</li> </ul> <p>Review of the provider's April 2013 Leftover Food policy revealed:</p> <ul style="list-style-type: none"> <li>**"Leftover food items which are not frozen, are</li> </ul>	F 371	<p>The Kitchen Cleaning/General Sanitation policy and procedures have been reviewed and updated by the Dietary Manager and Consultant RD. Cleaning tasks are now assigned to specific job positions. When the task is completed, the staff member will initial and date the cleaning schedule. The CDM will monitor the cleaning schedule and visually inspect the completed tasks weekly for completion. When 3 consecutive months show the tasks are being completed each week and are visually inspected by the CDM as they should be, the CDM will then monitor the schedules monthly for completion of tasks and report findings to the Administrator monthly. When 3 consecutive months show that tasks are being completed as assigned, this will no longer be reviewed for QA on a quarterly basis.</p> <p>The tartar sauce, the salsa, the cottage cheese, and the half-and-half mentioned were discarded on 5/19/15.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUN DIAL MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219</b>		
(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 371	Continued From page 2 held no longer than (3) three days before they are used or disposed of, with the following exceptions: -"Dairy product that have the original seal broken must be used within (7) seven days of opening regardless of the expiration date issued on the container." -"Condiments with the original seal broken may be kept for one month, unless manufacturer states longer." -"All staff are responsible to throw out any outdated food items, whether the seal is broken or not."  Interview on 5/19/15 at 3:20 p.m. with the registered dietician revealed she had: *Noted outdated food items before and had spoken to the dietary staff about it. *Also spoken to them about cleanliness in the kitchen.  Interview on 5/20/15 at 9:30 a.m. with the dietary manager revealed: *She was unaware of the missing times on the kitchen cleaning checklist and agreed the kitchen could have been cleaner. *She was unaware of the outdated food currently contained in the walk-in refrigerator.  Interview on 5/20/15 at 10:15 a.m. with the director of nursing revealed she agreed kitchen cleaning and outdated food would need to be taken care of to prevent cross contamination of bacteria.	F 371	The Leftover/Expired Food Policy was reviewed and updated by the CDM and Consultant RD. "Use By" dates will be marked on all items which have the original seal broken, by the person breaking the seal. The weekend cook will be responsible for checking the coolers to make sure all items have been marked appropriately. The inventory clerk will monitor for expired items when stocking new products on delivery days. All staff have the authority and responsibility to discard any out-dated food items, whether the seal is broken or not. The CDM will monitor the coolers on a weekly basis to ensure no expired/outdated foods are found and will report findings to the Administrator monthly.	7-9-15	
F 372 SS=B	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse	F 372			

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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 372	<p>Continued From page 3 properly.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and policy review, the provider failed to maintain the outside garbage container in a sanitary manner. Findings include:</p> <p>1. Observation on 5/19/15 at 1:30 p.m. of the trash bin located on the outside of the building revealed it to be overflowing with garbage with the lids open and six bags of trash on top of the container.</p> <p>Interview with the dietary manager who was outside at that time revealed: *Trash pick up was on Tuesday and Friday. *She thought the trash overflowed the bin more often lately.</p> <p>Interview on 5/20/15 at 8:30 a.m. with the maintenance supervisor revealed: *He agreed the trash was picked up on the above days, and it was overflowing the bin more often than not. *Nothing had been agreed on to address the problem. *He agreed it was a sanitation issue and had the potential to draw pests.</p> <p>Interview on 5/20/15 at 10:30 a.m. with the administrator revealed she thought the trash bin overflow was a one time problem.</p> <p>Review of the provider's May 2013 Sanitation policy revealed: "The holding, transferring and</p>	F 372	<p>An additional dumpster was delivered on 6/11/15. This dumpster will be used for broken-down cardboard boxes to eliminate large awkwardly-shaped items from taking up space in the main dumpster. The main dumpster will be used only for bagged garbage. All staff were messaged on our CareTracker system how garbage is to be placed in the last dumpster sections first, then the middle sections, and, lastly, the front sections. In addition, it will be stressed that the dumpster lids must be closed. A daily checklist is posted by the service door to document compliance with these procedures. The Group 1 Day-shift CNA who takes out the garbage will be responsible to check to verify that the dumpster is being loaded properly and that the lids are being closed. These procedures were reviewed with both the Dietary and Nursing staff at an Inservice. The Administrator will be responsible to visually monitor the dumpsters and to check the list weekly to verify that this is being done. The Administrator will report monthly results to QA quarterly. When 3 months of 100 % compliance is achieved, this QA study will no longer be done.</p>	6-12-15	

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NAME OF PROVIDER OR SUPPLIER  <b>SUN DIAL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219</b>
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F 372	Continued From page 4 disposing of garbage is done in a manner that will not create a nuisance or a breeding place for insects and rodents, or otherwise permit the transmission of disease."	F 372		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p>	F 431		

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NAME OF PROVIDER OR SUPPLIER  <b>SUN DIAL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219</b>
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F 431	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 35121 Based on observation, interview, and policy review, the provider failed to ensure limited access by unauthorized staff to residents' discarded fentanyl skin patches (narcotic pain medication) in one of one south wing storage room. Findings include:</p> <p>1. Interview on 5/19/15 at 10:50 a.m. with registered nurse (RN) B revealed: *She would have: -Folded used fentanyl patches and placed them in the sharps containers (disposal for dirty needles and syringes) attached to the medication carts. -Placed full sharps containers in the south wing storage room in a box for hazardous waste. *The charge nurses and the director of nursing (DON) had keys to that room. *She was not aware of who else might have had keys to that room.</p> <p>Observation on 5/19/15 at 11:00 a.m. of the south wing storage room with registered nurse B revealed several sharps containers in a box for hazardous waste.</p> <p>Interview on 5/20/15 at 10:35 a.m. with the DON revealed: *Their process for destruction of used fentanyl patches was to: -Fold used fentanyl patches and place in a sharps container. -Place full sharps containers in the south wing</p>	F 431	<p>F431-Sharps containers that were stored in the locked closet were picked up by our Medical Waste contractor on 5/25/15.</p> <p>Nurses were immediately informed not to put the used Fentanyl patches in the sharps containers, and informed to flush the used patches. The Policy for Controlled/Scheduled Medications was revised and reads to flush used Fentanyl patches down the toilet. This action is then recorded on the Controlled Drug Administration Record verifying the date and time of disposal and witnessed by two nurses verifying that the patch was flushed. The revised policy was placed at the</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	<p>Continued From page 6</p> <p>storage room in a hazardous waste box. *The key for the south wing storage room was the master key. *Keys for the south wing storage room had been in the possession of the: -Charge nurses. -DON. -Assistant DON. -Maintenance man.</p> <p>Interview on 5/20/15 at 10:45 a.m. with licensed practical nurse C revealed she would have folded the fentanyl patches and placed them in the sharps container.</p> <p>Review of the provider's July 2013 Controlled/Scheduled Medications policy revealed: **"Only authorized licensed nursing personnel have access to controlled drugs." **"Such drugs must be destroyed in accordance with policies outlined in a separate policy...entitled Destroying Medication."</p> <p>Review of the provider's July 2002 Destroying Medications policy revealed: *Schedule II drugs (medication with a high potential for abuse) must be destroyed by the DON or RN and the pharmacist. *There was no specific direction for the destruction of fentanyl patches.</p>	F 431	<p>(continued) nurses' station for review by the nurses. Education on the revised policy and procedure will be discussed at the nursing inservice on 6/16/15. The DON will complete a QA study by randomly choosing three Controlled/Scheduled Medication Records a month to check that nurses have initialed to verify that the patches were flushed. The results of this monitoring will be reported at the next QA meeting on 7/8/15. This will be monitored for 2 months. If we are not 100% compliant, we will again continue monitoring this until we have 3 consecutive months of 100% compliance.</p>	7-8-15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435093</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/19/2015</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SUN DIAL MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219</b>
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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
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/19/15. Sun Dial Manor was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Peggy L. Pearson, Administrator</i>	TITLE	(X6) DATE <i>6-11-15</i>
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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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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10598</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/20/2015</b>
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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	<b>Initial Comments</b>  Surveyor: 32332 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 5/18/15 through 5/20/15. Sun Dial Manor was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Reggie L. Pearson, Administrator*

STATE FORM

6899

JYPL11

