## Statement of Deficiencies and Plan of Correction

### Provider/Supplier/Clinical Identification Number:
- **435093**

### Multiple Construction
- A. Building
- B. Wing

### Date Survey Completed
- **09/2019**

### Name of Provider or Supplier
- **SUN Dial MANOR**

### Address, City, State, Zip Code
- **410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219**

### Summary Statement of Deficiencies

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<th>ID</th>
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<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
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- **Surveyor: 32335**
- A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/7/19 through 10/9/19. Sun Dial Manor was found not in compliance with the following requirements: F582, F658, F803, 812, and F880.

- **Medicaid/Medicare Coverage/Liability Notice**
- CFR(s): 483.10(g)(17)(iv)(v)

- **§483.10(g)(17)** The facility must—
  1. Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of—
     - A. The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
     - B. Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
  2. 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.
  1. Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide

### Provider's Plan of Correction

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<td>F 000</td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
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- The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to

- **The Business Office Manager will monitor the CMS website quarterly to ensure compliance of current forms.**
- **Business Office Manager will provide notices to residents 48 hours before services end.**
- **Completed notices will be approved by the administrator or DON for compliance and timeliness.**
- **The Business office manager will keep a log which will include the dates CMS website was checked for updated forms and will also track the residents that received notice, the date they received notice and the date of the last day of service.**
- **Business office manager will report to the QAPI committee quarterly until the committee decides compliance is being met.**

### Laboratory Director's or Provider/Supplier Representative's Signature

**Patricia Olson**

**Emergency Permit Holder**

**10/31/2019**

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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.
Continued from page 1

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.

(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:

Surveyor: 32335

Based on record review and interview, the provider failed to ensure appropriate and timely Medicare notices had been provided for one of one sampled current resident (23) and one of one random resident who had remained in the facility following their discharge from skilled services.

Findings include:

1. Review of resident 23’s medical record revealed:
   * She had met her therapy goals and had been discharged from therapy services on 9/28/16.
   * She had covered days remaining and continued
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tr>
<td>F 582</td>
<td>Continued From page 2</td>
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<td>to reside in the facility. *She had not received the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form as required. *The Notice of Medicare Non-Coverage (NOMNC) form had been adjusted and had not been the required Center for Medicare and Medicaid Services (CMS) form. Review of one random resident's medical record revealed: *He had been discharged from therapy services on 9/13/19. *He had covered days remaining and continued to reside in the facility. *He had not received the SNF ABN form as required. *The NOMNC form had been adjusted and had not been the required CMS form. *The adjusted NOMNC form had been signed by the resident on 9/12/19. *He had not been given forty-eight hours notice prior to his services ending. Interview on 10/9/19 at 2:50 p.m. with the emergency permit holder revealed she had not been aware the SNF ABN form was required. She was not aware the NOMNC should not have been adjusted. All residents should have been provided forty-eight hour notices when services were ending.</td>
<td>F 582</td>
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<td>See Page 1</td>
<td>11/23/2019</td>
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<td>F 658</td>
<td>Services Provided Meet Professional Standards</td>
<td>CFR(s): 483.21(b)(3)(i)</td>
<td>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</td>
<td>F 658</td>
<td></td>
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<td>See next page</td>
<td>11/28/2019</td>
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<td>F 658</td>
<td>F 658</td>
<td>Continued From page 3</td>
<td>The DON and IDT team in collaboration with the medical director reviewed and revised as necessary the policy and procedures for a bowel management program. A policy and procedure for a bowel management program was initiated and education was provided to nurses and CNA's at the nursing meeting. Resident 9 received Lactulose and had a BM 10/8/19. Reviewed all other resident records of BM's within the last week to make sure residents did not go over 3 days without BM. Since we initiated the bowel management program, there will be a monthly calendar for the bowel management program. The night nurse will document name of resident and if BM delayed for 48 to 72 hrs. The DON will audit the calendar each month to assure accurate monitoring and documentation for bowel elimination. The report of compliance will be reported monthly at the QAPI meeting until committee decides compliance is consistent.</td>
<td>11/28/2019</td>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tr>
<td>435093</td>
<td>A: BUILDING</td>
<td>10/09/2019</td>
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NAME OF PROVIDER OR SUPPLIER: SUN DIAL MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 410 SECOND STREET POST OFFICE BOX 337 BRISTOL, SD 57219
Continued From page 4

Review of resident 9's bowel records from 8/1/19 through 10/8/19 revealed:
*From 8/28/19 through 9/1/19 she had gone three days without having a bowel movement.
*From 10/3/19 through 10/8/19 she had gone four days without having a bowel movement.

Review of resident 9's August 2019 and October 2019 medication administration records revealed:
*She had an order for bisacodyl suppository 10 milligram, insert one application rectally every twenty-four hours as needed for constipation.
*She had not received any suppositories throughout those two months.

Review of resident 9's nursing notes from 8/10/19 through 10/9/19 revealed there were no notes regarding her not having a bowel movement during the above time frames.

Interview on 10/9/19 at 10:49 a.m. with the director of nursing (DCN) revealed:
*The night nurse made up a list of residents who had not had a bowel movement after two days.
*After two days with no bowel movement she would expect the nurses to have given an oral medication like Milk of Magnesia.
*At three days with no bowel movement they should have given a suppository.

Interview on 10/9/19 at 1:50 p.m. with registered nurse C revealed:
*The night shift would leave a note for the day shift of residents who had not had a bowel movement in three days.
*She had not recalled if resident 9 had been on the list.
*She stated if a resident had not had a bowel movement in three days they would give what
### SUMMARY STATEMENT OF DEFICIENCIES

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<td>F 658</td>
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<td>Continued From page 5 was ordered. *She was not aware of giving an oral medication after two days of not having a bowel movement.</td>
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<td>F 803</td>
<td>SS=E</td>
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<td>Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by:</td>
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### PROVIDER'S PLAN OF CORRECTION

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<tr>
<td>F 803</td>
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<td>The administrator and dietary manager in collaboration with the registered dietician will review and revise as necessary the policies and procedures about staff education, resident menu grievances, food presentation, hand hygiene and handling of ready to eat foods, and sanitary storage preparation and serving. The dietary staff will present the daily menu to residents for the next meal ahead of time so the resident can choose an alternate if they do not want the main menu items. The menus are checked and approved by the dietician monthly. The dietary manager will audit meal service once per week for four weeks and monthly for two more months to ensure that residents were served the meal of their choice. The dietary manager will report audit findings at the monthly QAPI meetings for further review and consideration. The activities manager will meet with the resident council once a month to review concerns. The concerns will be addressed by department head within 10 business days. If concerns are not addressed, the activity director will bring the concerns to the IDT team for further review. The IDT team will then put together a QAPI project and the effectiveness will be monitored for 6 months. <strong>See next page</strong></td>
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SUN DIAL MANOR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(PREFIX) (TAG) SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 803 Continued From page 6
Surveyor: 26632

Based on interview, record review, and policy review, the provider failed to ensure four of four randomly observed residents (4, 12, 17, and 29) and one of one resident council concerns regarding food taste and menu options were addressed. Findings include:

Surveyor 26632
1. Interview on 10/7/19 at 5:30 p.m. with resident 29 and again on 10/8/19 at 9:43 a.m. revealed:
   "The food did not taste good. It actually had no taste to it."
   "The evening meals had too "heavy" of food. Soup and a sandwich would have been best."
   "Sometimes they did not know what was being served as the names were fancy and unrecognizable."

Surveyor 32335
2. Interview on 10/8/19 at 11:00 a.m. with resident 12 revealed he did not like the food. He did not feel most of it tasted very good. He had told staff but did not feel anything had changed.

Surveyor 26632
3. Interview on 10/8/19 at 11:29 a.m. with resident 4 revealed:
   "She had expected healthier food to have been served.
   "There was too much pasta, and it was only half cooked.
   "There were no seasonings put in the food, so it was very bland.
   "The vegetables were always overcooked."
   "The meat was usually tough and hard to cut and chew."

(PREFIX) (TAG) PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
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DEFICIENCY)

F 803 Grievance officer met with resident 29 and discussed
POC to address meals. Discussed that new menus are being developed with RD to simplify the food
description on the menus and that alternate will be offered at each meal. Kitchen Manager and
Grievance officer will audit meals

Grievance officer met with resident 12 to go over
likes/dislikes to make sure they are documented on
the dietary card. Discussed that new menus are being developed with RD to simplify the food
description on the menus and that alternate will be offered at each meal. Kitchen Manager and
Grievance officer will audit meals

Grievance officer met with resident 4 to go over
likes/dislikes and options for food. Dietary card now
reflects resident likes double portions of vegetables
and half portions of carbs and starches. Discussed
that new menus are being developed with RD to
simplify the food description on the menus and that
alternate will be offered at each meal. Kitchen
Manager and Grievance officer will audit meals.

Grievance officer met with resident 17 to go over
meal concerns. Discussed that new menus are being
developed with RD to simplify the food description
on the menus and that alternate will be offered at
each meal. Kitchen Manager and Grievance officer
will audit meals.

Findings will be shared in monthly QAPI meetings
for 3 months for review and consideration.
F 803 Continued From page 7
*The names of the food on the menu did not reflect what it really was.

4. Interview on 10/8/19 at 12:57 p.m. with resident 17 revealed:
*She had many issues regarding the food.
*It was a "strange menu and has weird names for the food."
*The supper menu was too heavy of food.
*There was no taste to the food.

Surveyor 32335
5. Confidential group interview on 10/8/19 at 3:20 p.m. revealed:
*The noodles were half cooked.
*Scalloped potatoes were raw.
*They just had potato salad a few days ago, and the potatoes were raw.
*The breaded meats were tough and hard to eat.
*They provided small packets of condiments instead of bottles, and several residents could not open the small packets.
*They did not get asked what they wanted; they were just served one option.
*Snacks did not always go out at night.
-One resident stated it had been weeks since she had been offered a snack after supper.
*They had been asking to have a relish tray and finally the staff stated they could have one on Mondays, but no other day of the week.
*The menus had names of dishes they did not know what they were. They wanted them to use plain language to identify the dishes.
*They had stated those concerns in resident council and did not feel they had been addressed.

Review of the July 2019, August 2019, and September 2019 resident council minutes revealed food concerns had been brought up at
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<td>F 803</td>
<td>Continued From page 8 each meeting with no resolution noted the following month.</td>
<td>F 803</td>
<td>See page 6 and 7</td>
<td>11/28/2019</td>
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6. Interview on 10/9/19 at 9:28 a.m. with the activity director regarding the food concerns brought up at resident council. She knew it was a problem. It was the same thing every month as nothing had been done regarding the residents' complaints.

Surveyor 26632 Interview on 10/9/19 at 9:30 a.m. with the kitchen manager revealed she was aware of the residents' food complaints. She had not informed the registered dietitian (RD) about the residents dislike of the menus. The current menus had been supplied by the past food supply company and reviewed by the RD. She had not contacted the new food supply company to check if they had menus that could be reviewed by the RD.

Interview on 10/9/19 at 1:00 p.m. with the director of nursing and assistant director of nursing revealed they had been aware many of the residents had not been happy with the current menus. Nothing had been done within the quality assurance performance improvement system to review the current menus and investigate what could have been done for the residents.

Review of the provider's 3/4/19 Grievance Procedure policy revealed:
"Residents and family are encouraged and assisted throughout their stay at Sun Dial Manor/Johnson Center to exercise their rights as a citizen."
"Residents/family are encouraged to voice grievances and recommend changes to policies and services to our staff and/or outside
F 803 Continued From page 9
representative of their choice.
**"The staff member will make every effort to
correct the situation as soon as possible."
**The policy had not addressed resident council
grievances.

F 812 Food Procurement, Store/Prepare/Serve-Sanitary
SS=F
§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
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:
Surveyor: 26632
Based on observation, record review, interview,
cleaning schedule review, and policy review, the
provider failed to:
*Ensure appropriate hand hygiene and glove use
during one of one observed meal by the kitchen
manager and one of one dietary aide (A).
*Handling of ready-to-eat foods by the kitchen
manager during one of one observed meal.
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<tr>
<td>Continued from page 10</td>
<td>Chemical storage moved from food area</td>
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<td>*One of one mechanical dishwasher had the chemical sanitization. *</td>
<td>The food storage area will be refinished with a cleanable surface. Product on order and installation scheduled</td>
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<td>*Maintain the cleanliness of the following areas: All filters in the hood over the grill were layered with grease. One of one mechanical dishwashing room was kept in a neat and clean manner. All of the kitchen rolling carts had been cleaned and sanitized on a regular basis. The walls in the kitchen had been maintained in a cleanable manner. Two of two garbage cans (handwashing sink and dishwasher area) were used to prevent contamination to the staff's hands. The entire kitchen floor was soiled with food particles, dirt, and grease in the grout lines. The oven, stove top, and convection oven had been cleaned. Oven trays had been stored to prevent a build-up of food particles, dirt, and grease. The walk-in refrigerator/freezer floor was kept free from food debris. All counters, drawers, and shelves had been kept clean. The flour and bread crumb container tops had been kept clean. The microwave had been kept clean. Chemicals had not been stored by the vegetable preparation sink. Two of two dry food storage room shelves were kept in a cleanable manner. Findings include:</td>
<td>Kitchen walls will be repaired by 10/31/2019. Maintenance Director or designee will audit kitchen walls once per month for three months to ensure the walls are well maintained. Maintenance director or designee will report audit findings at the monthly QAPI meetings for review and further consideration. Dietary Aide A, dietary staff and dietary manager have been trained to change gloves if other surfaces are touched with gloved hands to meet sanitary requirements. The process for monitoring or testing the chemicals in the dishwasher have been reviewed with the dietary staff. They are to follow the policy and test the sanitizer with Litmus strips and result is to read SO+. The water temp is to be no lower than 120 degrees and rinse 120-140 degrees. Dietary manager will audit and report at monthly QAPI meeting for 3 months for review and consideration. The filters in the hood, the mechanical dishwashing room, kitchen rolling carts, garbage cans, kitchen floor, ovens, walk in refrigerators/freezers, counters and microwave have been cleaned. The cleaning schedule is posted and kitchen manager will audit and report at monthly QAPI meeting for 3 months for review</td>
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**F 812** Continued From page 11

assistant (CNA)/bath aide.

*She had worked in the kitchen prior to becoming a CNA.

*There were three staff that had current Serv-Safe certifications: herself, the social service designee (SSD), and an activity assistant. The SSD and the activity assistant did not work in the kitchen.

*The SSD was also a certified dietary manager (CDM).

*Staff were in the process of getting ready to serve the supper meal.

*The kitchen walls, floors, cabinet and drawer fronts, steam table, stove, and convection oven had food debris, grease, and dirt not on and in them.

b. Observation during the evening meal on 10/7/19 from 5:00 p.m. through 5:30 p.m. revealed:

*The kitchen manager dished up food for the assisted living center (ALC) plates.

*She had gloves on and did not change them during the entire process.

*She used a soiled pot holder to pull clean plates out of the oven. Those plates were in the oven to ensure the food was kept warm.

*She picked each biscuit up with her gloved hands.

*She retrieved small dishes from a tub on the counter by placing her fingers inside of the dish. *Dietary Aide (DA) A wore the same gloves during the observation from 5:00 p.m. through 5:17 p.m.

During that time she had touched many surfaces in the kitchen with her gloves on. Those included the cupboards, utensil drawers, and refrigerator in the kitchen. She dished the Jello with fruit into small bowls using a spatula. She touched the inside of the bowls with her thumb and at times...
**F 812** Continued From page 12

the Jello to prevent it from sliding off the spatula.  
*At 5:05 p.m. the kitchen manager delivered the food to the ALC. She had taken her gloves off prior to that but had not completed any hand hygiene.  
*At 5:10 p.m. DA A with her same gloves on as above delivered the Jello out to the dining room. An unidentified resident dropped some of her Jello on the floor. DA A took a napkin, picked up that spilled Jello, disposed of it in the garbage by the dishwasher, and brought the resident a new dish of Jello.
-When she had disposed of the Jello she had lifted the garbage can cover off with those same gloved hands. She still had not changed her gloves.
*At 5:12 p.m. the kitchen manager returned to the kitchen. She washed her hands for approximately ten seconds. When she went to dispose of the paper towel she lifted the cover with her bare hands. -She did not use the foot control to open the garbage can. She then put on new gloves.  
*At 5:17 p.m. DA A washed her hands. She opened the garbage can the same as the kitchen manager. -That had been the first time she had been observed washing her hands.
*At 5:20 p.m. The kitchen manager started to dish food up for the nursing home residents. She handled all the biscuits with her gloved hands. She had retrieved two food processor containers, pureed food, and touched all of the residents' diet cards with those gloves on before handling the food.

Interview on 10/7/19 at 5:40 p.m. with the kitchen manager confirmed she had touched the biscuits with her gloved hands and had touched other surfaces while wearing those gloves.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**SUN DIAL MANOR**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

410 SECOND STREET POST OFFICE BOX 337
BRISTOL, SD 57219

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**SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)**

**F 812**

Continued From page 13

c. Observation of the kitchen on 10/8/19 from 8:30 a.m. through 9:30 a.m. revealed:

*The floor in the kitchen and attached food storage room was soiled with food particles, dirt, and grease in the grout lines. The surface did not appear to have been swept or mopped from the evening observation on 10/7/19.

*The gas stove top had a large amount of dried and cooked food debris.

- The gas oven and the convection oven also had a large amount of food debris inside of it.

- Oven racks had been stored on the floor between the ovens.

*The walk-in refrigerator/freezer floors had a moderate amount of food debris on the floors.

* A wall by the walk-in refrigerator/freezer unit had an approximate six inch round hole in it.

*The outside corners of the walls in the kitchen had various amounts of damage. That damage ranged from paint missing to the to the gypsum board completely missing.

* The walls, counter tops, inside of the drawers, the outside and the inside of the cupboards, and the shelf surfaces all had food debris, dust, and grease on them and inside of them.

* The dishwashing room had a large amount of dirt and grease on the floor.

* The chemicals used in the dishwasher during the rinse cycle were not monitored or tested that they were at appropriate levels.

* The outside of the dishwasher was also dirty with grease and dirt on it.

* The microwave had a moderate amount of spilled and cooked food on the walls and bottom of it.

* The two compartment vegetable preparation sink counter contained cleaning chemicals.

* Two of two mixers had a large amount of dried food on them.

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**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

F 812 See pages 10 and 11

**COMPLETION DATE**

11/28/2019
### F 812

Continued From page 14

*The food storage rooms had unfinished wooden shelves making them uncleanable surfaces.

Interviews on 10/9/19 with the following staff members revealed:

*At 9:00 a.m. the emergency permit holder stated she was aware of the kitchen condition. There had been staff turnover.
-She stated she was the "administrator only on paper" and had not done anything to address the kitchen condition.
*At 9:30 a.m. the director of nursing and assistant director of nursing were aware of the condition of the kitchen.
-There had been a large amount of staff turnover. It had not been addressed in the quality assurance performance improvement plan.
*At 10:00 a.m. with the maintenance supervisor. He was not aware of the condition of the walls.
-Staff were to report needed repairs to him and then he would fix them.
*At 10:15 a.m. the kitchen manager regarding the cleaning of the kitchen was aware of what needed to be done to ensure the kitchen stayed in a sanitary manner.
- She had made up a cleaning schedule, but they had not been initiated yet.

Review of the registered dietitian/licensed nutritionist monthly visits and observations revealed:

*On 7/10/19 she had noted the following:
-Gloves had not worn gloves during food preparation.
-Keep food items away from area that chemicals had been kept.
-The cleaning schedule had not been posted or followed.
*On 8/7/19 she had noted the following:
Continued From page 15
-The cleaning schedule had not been posted or followed.
-There were observable dirty areas in the kitchen.
-All equipment was clean and sanitized.
-The microwave had not been cleaned.
*On 9/4/19 she had noted the following:
-No gloves were used with ready-to-eat items.
-There were observable dirty areas in the kitchen.
-There was food on the floor of the dry storage room.

d. Review of the provider's 2013 General Food Preparation and Handling policy revealed:
*The kitchen and equipment would have been clean and sanitized as appropriate.
*Food would have been prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements to avoid manual contact of the prepared foods.

Review of the provider's 2013 Hand Washing policy revealed hands should have been washed before putting on gloves when working with food.

Review of the provider's 2013 Bare Hand Contact with Food and Use of Plastic Gloves policy revealed:
*Gloved hands were considered a food contact surface that could get contaminated or soiled. If used, single use gloves should have been used for only one task, used for not another purpose, and discarded when damaged or soiled.
**Gloves are just like hands. They get soiled. Anytime a contaminated surface is touched, the gloves must be changed."

Review of the provider's 2013 Cleaning and Sanitation of Dining and Food Service Areas policy revealed:
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED: 10/09/2019

NAME OF PROVIDER OR SUPPLIER
SUN DIAL MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE
410 SECOND STREET POST OFFICE BOX 337
BRISTOL, SD 57219

(X4) ID PREFIX TAG

F 812 Continued From page 16
*The food service staff would have maintained the cleanliness and sanitation of the food service areas through compliance with a written and comprehensive cleaning schedule.
*A cleaning schedule would have been posted for all cleaning tasks.

Review of the provider’s 2013 Cleaning Instructions: Cabinets and Drawers revealed cabinets and drawers would have been cleaned at least twice a month.

F 880 Infection Prevention & Control

CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPC P) 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 §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and

F 812 See pages 10 and 11

F 880

Infection Control Program was reviewed.
Policy for prevention and control of infection, system of surveillance and outbreaks policy and procedure was reviewed.
A new laundry transportation cart was ordered.
The laundry is now covered and the cart has a solid bottom shelf preventing transmission of contamination of organisms. A plastic liner with a cover has been ordered to line the wire mesh cart that is used to transport clean laundry.
The policy for transporting linens was reviewed.
Laundry personnel will be educated on the policy for transporting linens properly. An observation and evaluation will be completed by the housekeeping supervisor. An audit will be performed monthly by the supervisor for three months. The housekeeping supervisor will report monthly at the QAPI meeting and will continue to audit until committee decides compliance is consistent.
F 880 Continued From page 17

procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review. The facility will conduct an annual review of its
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435093

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED: 10/09/2019

**NAME OF PROVIDER OR SUPPLIER**

SUN DIAL MANOR

**STREET ADDRESS, CITY, STATE, ZIP CODE**

410 SECOND STREET POST OFFICE BOX 337
BRISTOL, SD 57219

<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
</table>
| F880 | Continued From page 18 | | IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and policy review, the provider failed to cover and transport clean linens to prevent contamination for two of two observations by one of one laundry aide (B). Findings include: 1. Observation on 10/08/19 at 1:20 p.m. of laundry aide B delivering personal laundry items in the west hall revealed: *She pushed a wire mesh laundry cart from room-to-room. *The clean laundry items were sitting directly on the wire-mesh basket with approximately two-inch openings between the mesh. *The bottom and sides of the basket were not covered, and that left the clean laundry exposed to the environment. *The laundry was covered with a small permeable cotton sheet.

Observation on 10/09/19 at 10:30 a.m. of laundry aide B delivering personal clothing in the west hall revealed:
*She was delivering the clothing on a hanging clothes rack.
*A worn bedsheet was placed an the top of the clothing hangers.
*Laundry aide B had not covered the clothing during the transport or while she was delivering the clothing into the residents' rooms.

Interview on 10/9/19 at 3:30 p.m. with the director of nursing and on 10/9/19 at 3:35 p.m. with the maintenance supervisor regarding laundry revealed their expectation was the linen and | F880 | See page 17 | |

| 1/28/2019 |
**F 880** Continued From page 19

personal laundry would have been handled in a manner to prevent potential contamination. The above concerns with laundry delivery had not been sanitary.

Review of the provider's July 1990 untitled Laundry policy regarding storage and transportation of clean linen revealed linens were to have been transported on a clean linen cart that was to have been covered.

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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 880</td>
<td>See page 17</td>
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**X2** MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

**X3** DATE SURVEY COMPLETED

10/09/2019
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<th>Summary Statement of Deficiencies</th>
<th>ID</th>
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<th>Provider's Plan of Correction</th>
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<tbody>
<tr>
<td>E000</td>
<td>Initial Comments</td>
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<td>E000</td>
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<td>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to</td>
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<td>E039</td>
<td>EP Testing Requirements</td>
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<td>E039</td>
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<td>Emergency plan will be reviewed and updated as necessary to include a tabletop exercise and a full-scale exercise.</td>
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<tr>
<td>SS=D</td>
<td>CFR(s): 483.73(d)(2)</td>
<td></td>
<td>(2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following:</td>
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<td>*[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:]</td>
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<td>(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.</td>
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<td>(ii) Conduct an additional exercise that may include, but is not limited to the following:</td>
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<td>(A) A second full-scale exercise that is community-based or individual, facility-based.</td>
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**Signature**

Patricia Olson

Emergency Permit Holder

10/31/19

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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 for the patients. (See Instructions.) Except for nursing homes, the findings stated above are discloseable 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 discloseable 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.
<table>
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<tr>
<th>E 039</th>
<th>Continued From page 1</th>
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| (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.  
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.  
*For RNHCl at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCl and OPO] must conduct exercises to test the emergency plan. The [RNHCl and OPO] must do the following:  
(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.  
(ii) Analyze the [RNHCl's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCl's and OPO's] emergency plan, as needed.  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 26632  
Based on record review and interview, the provider failed to ensure a desk top exercise and a full scale exercise had been conducted on an annual basis. Findings include:  
1. Review of the provider's emergency preparedness plan included education that had been given to the staff as part of the yearly | E 039 | See page 1 |
E 039 Continued From page 2

Education. There was no documentation a desk top exercise and a full scale exercise had been conducted.

Interview on 10/9/19 at 1:00 p.m. with the maintenance supervisor revealed he was not aware those exercises should have been conducted on an annual basis. He did not have those as part of the emergency preparedness plan.

E 039 See page 1
**K 000**

**INITIAL COMMENTS**

Surveyor: 40506  
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/8/19. Sun Dial Manor was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K271 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

**K 271**

**Discharge from Exits**

SS-D CFR(s): NFPA 101

Discharge from Exits  
Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 40506  
Based on observation and interview, the provider failed to arrange exit discharge as required. The exit discharge did not meet change in elevation requirements (the east wing exit). Findings include:

1. Observation at 10:45 a.m. on 10/8/19 revealed the east wing exit of Sun Dial Manor discharged to a concrete pad. That pad discharged to the...
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<tr>
<td>K 271</td>
<td>Continued From page 1</td>
<td>sidewalk leading to the public way. The elevation difference at discharge was between one and one half and two inches. Code requires that no abrupt changes in elevation greater than one-quarter inch occur at the exit discharge.</td>
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<td>K 271</td>
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<td>Interview with the maintenance supervisor who was present when the deficiency was identified noted he had painted the change in elevation during the summer of 2018.</td>
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<td>Failure to arrange exit discharge as required increases the risk of death or injury due to fire.</td>
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<td>The deficiency affected an estimated one of three resident wings in the facility and one of five exit doors.</td>
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<td>Ref: 2012 NFPA 101 Section 19.2.7, 7.7.4, 7.1.8.2</td>
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Compliance/Noncompliance Statement

Surveyor: 32335

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/7/19 through 10/9/19. Sun Dial Manor was found in compliance with the following requirements: S301 and S314.

44:73:07:16 Required Dietary Inservice Training

The dietary manager or the dietician shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.

This Administrative Rule of South Dakota is not met as evidenced by:

Surveyor: 26632

Based on interview, training, and orientation review, the provider failed to ensure dietary employees had received all the required dietary training. Findings include:

1. Interview on 10/8/19 at 9:30 a.m. with the kitchen manager revealed she had not received any dietary inservice training. She was current until 10/30/19 for her ServSafe certification. She was not aware all dietary and food handling employees were to have training that included: food safety, handwashing, food handling and preparation techniques, food borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements.
Continued From page 1

hydration, and sanitation requirements.

Interview on 10/9/19 at 1:00 p.m. with the assistant director of nursing revealed the above training was not provided to the dietary employees.

Review of the provider's 2013 Training/Orientation policy revealed all dietary staff were to have completed education on: sanitation, safety, food preparation, food safety, nutrition, therapeutic diets, and also the review of the policies and procedures.

**S 314 44.73:08:03 Medication Therapy Reviewed Monthly**

The pharmacist shall review the drug regimen at least monthly. The pharmacist shall review the resident's diagnosis, the drug regimen, and any pertinent laboratory findings and dietary considerations. The pharmacist shall report potential drug therapy irregularities and make recommendations for improving the drug therapy of the residents to the attending physician, physician assistant, or nurse practitioner and the administrator. The pharmacist shall document the review by preparing a monthly report of the potential irregularities and recommendations. The administrator shall retain the report in the facility. A copy of the medication review shall be in the resident medical record.

The pharmaceutical service shall be under the supervision of a licensed pharmacist who provides consultation and oversees all aspects of the pharmaceutical services.

This Administrative Rule of South Dakota is not
## SUN DIAL MANOR

**Address:**
410 2ND STREET POST OFFICE BOX 337
BRISTOL, SD 57219

### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>ID</th>
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<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
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<tbody>
<tr>
<td>S 314</td>
<td>Continued From page 2</td>
<td>See page 2</td>
<td>met as evidenced by: Surveyor: 26632 Based on interview and record review, the provider failed to ensure monthly drug regimen reviews were maintained in residents' medical records for all residents. Findings include: 1. Record review and interview on 10/8/19 at 11:00 a.m., with the assistant director of nursing (ADON) revealed: *When reviewing residents' medical records it was noted no pharmacist (RPh) recommendations. *The ADON had the RPh review documentation for all the residents. *The RPh then recorded his recommendations on a separate document. *The document contained a list of all residents. She stated no copy of the RPh individual reviews were placed in the residents' medical record. *She was not aware of the need for the pharmacy review to have been placed in each residents' record. *There was no policy in regards to the pharmacist reviews.</td>
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<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement</td>
<td></td>
<td>Surveyor: 32335 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 10/7/19 through 10/9/19. Sun Dial Manor was found in compliance.</td>
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