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

PRINTED: 10/28/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 - 6	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		435093	B. WNG			10/21/2020		
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	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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLETION		
F 000	INITIAL COMMENTS Surveyor: 26632 A COVID-19 Focused Infection Control Survey		F	000				
	of Health Licensure a 10/21/20. SunDial Ma compliance with 42 C rights and 42 CFR Pa regulation(s): F550, F F882, F885, and F88	FR Part 483.10 resident art 483.80 infection control 562, F563, F583, F880, 6. bund in compliance with 42						
	Total residents: 32							
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Tammy Conskin					Administrator 10	(X6) DATE 10/28/2020		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete OCT 2 8 2020 Event ID: QN9911

Facility ID: 0084

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