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 _____	C 07/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/19/21 through 7/22/21. Sun Dial Manor was found not in compliance with the following requirements: F550, F658, F700, and F755. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 7/19/21 through 7/22/21. Areas surveyed included resident neglect. Sun Dial Manor was found not in compliance with the following requirement: F658.	F 000	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 deficiences. 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	
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550	The Director of Nursing will review and revise as necessary the policy and procedures regarding assistance of residents in the dining room in a timely manner. The Director or Nursing or designee will present updated dining assistance policy and procedures at the QAPI meeting for further review and approval. Residents 4 and 7 as well as other residents affected by this deficiency care plans will be reviewed to ensure appropriate dining assistance during meals in a timely manner. The Director of Nursing or designee will re-educate the staff responsible for assisting in the dining room on the updated policy and procedures. The Director of Nursing or designee will audit resident dining assistance three times per week for 4 weeks to ensure the residents are receiving the appropriate dining assistance, then the audits will be moved to once per month for two more months. The Director of Nursing will present the audit findings at the monthly QAPI meetings for review and consideration.	08/27/2021

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

Erin Wattier | Director of Nursing | 08/05/2021

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 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (4 and 7) had been assisted in the dining room in a timely manner. 1. Observation on 7/19/21 from 5:07 p.m. through 5:48 p.m. during the supper meal revealed: *Resident 7 was sitting at the dining room table with her drinks in front of her. -She was not able to drink from the glasses independently. -There were two other residents at the table with their supper meal and eating independently. -5:12 p.m. a nurse set a plastic cup in front of her which appeared to be a nutritional supplement. --The nurse did not attempt to assist her to drink the supplement.	F 550		

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F 550	Continued From page 2 -5:26 p.m. an employee set a bowl of dessert in front of her but did not offer any assistance. -5:30 p.m. an unidentified certified nursing assistant (CNA) sat down next to her, her supper meal was served, and the CNA assisted her to eat. *Resident 4 was sitting at the dining room table with his drinks in front of him but out of reach. -Both resident who were sitting at the table with him had eaten supper and left the dining room. -He had appeared to become anxious, he was trying to stand up on his own and had removed his clothing protector and was fidgeting with it. -5:48 p.m. an unidentified CNA entered the dining room, ordered his plate from the kitchen, and then sat down to assist him with his meal. Observation on 7/20/21 from 11:38 a.m. through 12:05 p.m. during the lunch meal revealed resident 7 was sitting at the dining room table: *Drinks and dessert were sitting in front of her but she could not drink or eat independently. *Two other residents at the table were drinking their liquids and eating their desserts. *Three different unidentified staff had stopped at the table to visit with her two table mates but had not offered her any assistance. *12:03 p.m. CNA D ordered her lunch plate and sat down to assist her eat. Interview on 7/21/21 at 8:40 a.m. with director of nursing (DON) A revealed: *She expected all residents at a table to be served at the same time. *Residents who needed assistance with eating should not be brought into the dining room until someone could assist them with the meal. Review of the provider's 2021 Policy and	F 550		

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F 550	Continued From page 3 Procedure The Dining Experience and Dining room service revealed: *"Individuals at the same table will be served and assisted at the same time." *"Adequate staff should be available in the dining areas to help individuals who need assistance and to handle any situation that may arise."	F 550		8
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to follow professional standards to ensure four of twelve sampled residents (10, 18, 24, and 81) had frequent skin assessments completed by a licensed nurse. 1. Review of resident 81's medical record on 7/21/21 revealed: *He had been admitted on 11/30/18. *His discharge date was 6/29/21. *His diagnoses included: peripheral vascular disease, anemia, muscle weakness, dementia, infection of the skin, and unspecified staphylococcus as the cause of diseases classified else where. *He had previously had a vascular wound to his left foot which had healed in May 2021. *On 6/13/21 his Braden Scale for predicting pressure sore risk had shown he was at risk for	F 658	The Director of Nursing will review and revise as necessary the skin and wound management policy and procedures to include weekly skin assessments by a licensed nurse for those residents at risk of a wound or those residents with an active wound. The Director of Nursing or designee will present the updated skin and wound management policy and procedures at the QAPI meeting for further review and approval. The Director of Nursing or designee will re-educate the staff responsible for wound care on the updated policy and procedures. Resident 10, 18, and 24 wound care will now include weekly skin assessments. Resident 81 has discharged from the facility so no more action is needed. All other residents with high risk for wound concerns or those with active wound treatment will have a weekly skin assessment implemented. The Director of Nursing or designee will audit resident's with wound care once per week for 4 weeks to ensure the staff are completing with weekly skin assessments, then audits will be moved to once per month for two more months. The Director of Nursing will present audit findings at the monthly QAPI meetings for review and consideration.	08/27/2021

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F 658	Continued From page 4 skin breakdown. *He was noted to have a vascular wound to his right foot on 6/9/21. *There had not been documentation of weekly head-to-toe skin assessments done by a licensed nurse. 2. Observation on 7/20/21 at 9:20 a.m. of resident 10 being assisted by certified nursing assistant (CNA) C and registered nurse (RN) B with a transfer from her wheelchair to her bed with a hoyer lift revealed she: *Had a large bruise to her lateral left upper arm. *Had told RN B she did not know what happened but that no one had hurt her. Review of resident 10's medical record on 7/21/21 revealed: *Diagnoses included: history of subdural hemorrhage, dysuria, cerebrovascular disease, transient cerebral ischemic attack, difficulty in walking, muscle weakness, and peripheral vascular disease. *On 5/8/21 her Braden scale for predicting pressure score risk had shown she was at moderate risk for skin breakdown. *She was incontinent of bowel and bladder. *An order to monitor lower extremities for breakdown every night shift. *Nurses note on 7/21/21 noted multiple bruises to her left arm. *There had not been documentation of weekly head-to-toe skin assessments done by a licensed nurse. Interview on 7/20/21 at 9:20 a.m. Interview with RN B about the bruises on resident 10's left arm revealed: *Resident 10 would often bump her arms on the	F 658		

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F 658	Continued From page 5 hoyer lift during cares, which is why she wore the arm protectors. *Had not been aware resident had the bruises prior to the above observation. *Would have to investigate the cause of the bruises. 3. Observation and interview on 7/20/21 at 3:09 p.m. of resident 24 with RN B revealed: *Resident 24 had a facility acquired pressure ulcer to her coccyx. *Has had the pressure ulcer since the end of April 2021. *RN B had said resident 24 did not like to lay down between meals but staff had been educating and encouraging her to lay down more often to take pressure off of her coccyx. *The pressure ulcer was open, the wound bed was pink and clean with a small amount of clear drainage. *Resident 24 had a pressure reducing mattress on the bed and pressure reducing cushion in her wheelchair. *Resident 24 had stated she had been trying to lie down between meals more but did not like to. -She told this surveyor she did not like to lie down during the day and often sat up in her wheelchair late in the evening. Review of resident 24's medical record on 7/21/21 revealed: *Diagnoses included: Parkinson's disease, frequent urination, weakness, obesity, and intervertebral disc degeneration to lumbar region. *On 6/13/21 her Braden Scale for predicting pressure sore risk had shown she was at moderate risk for skin impairment. *She had a pressure ulcer on her coccyx and her left heel.	F 658		

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F 658	Continued From page 6 *She often refused to lay down to off load in her bed. *She had pressure relieving devices on her bed and in her wheelchair. *There had not been documentation of weekly head-to-toe skin assessments done by a licensed nurse. Surveyor: 43844 4. Review of resident 18's medical record revealed: *She had been admitted on 12/16/20. *Her diagnosis included muscle weakness; pain in right foot; other abnormalities of gait and mobility: calcaneal spur, left foot: and, anemia. *Her Braden Scale for predicting pressure sore risk had shown she was at risk for skin breakdown. *She currently had a pressure ulcer on her left heel. -There had been documentation of a weekly skin assessment for her left heel. *There had not been documentation of weekly head-to-toe assessments done by a licensed nurse. Surveyor: 41895 5. Interview on 7/21/21 at 10:03 a.m. with RN B revealed: *If the cause of a bruise or skin injury is unknown or suspicious they would complete an investigation. *The nurses did not do weekly head-to-toe skin assessments. *The bath aide looked at the skin with baths and reported to the nurse if she saw any impairment to the residents skin. *A licensed nurse did a full head-to-toe skin assessment quarterly.	F 658		

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F 658	Continued From page 7 Interview on 7/22/21 at 8:42 AM with director of nursing (DON) A revealed: *Residents were scheduled for a head-to-toe skin assessments by a licensed nurse quarterly. *It was the CNA's responsibility to inform the nurses when they saw impairments to residents skin. *She had agree it was not in the CNA's scope of practice to complete head-to-toe skin assessments. *She had not know skin assessments should have been completed by a licensed nurse more often then quarterly. *The provider did not have a specific reference source they used for guidance on professional standards. *The facility policy's had been written prior to her hire date and she had been aware they needed to be updated. 6. Review of the provider's revised June 2020 Skin Care Policy and Procedure revealed: *"Skin assessments will be performed by a licensed nurse as follows: 1. head to toe, on admission 2. skilled charting monthly 3. head to toe, with each MDS [Minimum Data Set] 4. as needed." *"Bath aide will assess skin weekly during the resident's bath, the bath aide will inform the charge nurse of any skin concerns as needed." Review of Lyder CH, Ayello EA. Pressure Ulcers: A Patient Safety Issue. In: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 12. Available from:	F 658		

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F 658	Continued From page 8 http://www.ncbi.nlm.nih.gov/books/NBK2650/) found in the State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities revealed: *"Moreover, by performing frequent skin assessments, nurses will be able to identify skin breakdown at an early stage, leading to early interventions. Although there is a lack of consensus as to what constitutes a minimal skin assessment, CMS recommends the following five parameters be included: skin temperature, color, turgor, moisture status, and integrity."	F 658		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced	F 700	The Director of Nursing will review and revise as necessary the policy and procedures for bed rails usage to include safety assessments. The Director of Nursing or designee will present updated bed rails policy and procedures at the QAPI meeting for further review and approval. The Director of Nursing or designee will re-educate the staff responsible for bed rail usage on the updated policy and procedures. Resident's 19 and 82 bed rail assessments were completed. All other residents with bed rails will be audited to make sure they have a current safety assessment. The Director of Nursing or designee will audit residents with bed rails once per week for 4 weeks to ensure the staff are completing the safety assessments, then the audits will be moved to once per month for two more months. The Director of Nursing will present audit findings at the monthly QAPI meetings for review and consideration.	08/27/2021

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F 700	Continued From page 9	F 700		

by:
Surveyor: 16385
Based on observation, interview, and policy review, the provider failed to ensure safety assessments were completed and documented for two of two sampled residents (19 and 82) who had quarter length side rails on their beds.
Findings include:

1. Observations of resident 82's bed revealed:
*On 7/20/21 at 9:10 a.m. one quarter side rail in the up position on resident's right side of bed.
*On 7/20/21 at 11:00 a.m. one quarter side rail in the up position on the resident's right side of bed.
*On 7/20/21 at 3:22 p.m. one quarter side rail in the up position on resident's right side of bed.
*On 7/21/21 8:47 a.m. one quarter side rail in the up position on resident's right side of bed.
*On 7/22/21 8:35 a.m. two quarter side rails on resident's bed in the up position.

Review of resident 82's medical record revealed no side rail safety assessments had been completed since her admission on 6/1/21.
Surveyor: 43844
2. Observation on 7/20/21 at 5:05 p.m. of resident 19's bed revealed two quarter size rails raised on his bed.

*Interview on 7/19/21 at 5:05 p.m. with resident 19 revealed he had been using the side rails when in bed.

Review of resident 19's physician's orders and care plan revealed:
*There had not been an order for side rails.
*The care plan did not include use of side rails.

Surveyor: 16385

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F 700	Continued From page 10 Interview on 7/22/21 8:06 a.m. with the director of nursing (DON) confirmed side rail safety assessments had not been completed for residents 82 and 19. She stated that an assessment was required if side rails were used. Review of the provider's 6/2020 Proper Use of Bed Rails policy revealed: "4. An assessment must be made to determine the resident's symptoms or reason for using bed rails. When used for mobility or transfer, an assessment should include a review of the resident's: a. Bed mobility; and b. Ability to transfer between positions, to and from bed or chair, to stand and toilet."	F 700		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755	The Director of Nursing will review and revise as necessary the policy and procedure for pharmacy services to include counting of controlled medications awaiting destruction in the medication room at change or shift. The Director of Nursing or designee will present updated pharmacy services policy and procedures at the QAPI meeting for further review and approval. The Director of Nursing or designee will re-educate the staff responsible for pharmacy services on the updated policy and procedures. Resident 9,81,82,83,84, and 85 as well as all other residents with controlled medications awaiting for destruction are accounted for at shift change. The Director of Nursing or designee will audit the medication room for controlled medications awaiting destruction once per week for 4 weeks to ensure there are no controlled medications awaiting destruction. Then the audits will be moved to once per month for two more months. The Director of Nursing will present audit findings at the monthly QAPI meetings for review and consideration.	08/27/2021

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F 755	Continued From page 11 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy reviewed the provider failed to ensure controlled medications awaiting destruction in the medication room had been counted at change of shift for six of six randomly sampled residents (9, 81, 82, 83, 84, and 85). Findings include: 1. Observation on 7/21/21 at 3:10 p.m. in the medication storage room revealed: *A locked cupboard which held extra controlled medications, emergency medication kit, and controlled medications awaiting destruction. *The controlled substances awaiting destruction were: -One bottle of lorazepam 2 mg (milligrams)/ml (milliliter) with a small amount of liquid left in it for resident 83. -One bottle of lorazepam 2 mg/ml with a small amount of liquid left in it for resident 84. -Eighty-seven tablets of Tramadol 50 mg for resident 81. -One-half tablet of hydrocodone-acetaminophen 5/325 mg for resident 9. -Fifteen tablets of oxycodone 5 mg for resident	F 755		

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 07/22/2021

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 755	Continued From page 12 82. -For resident 85: --Fifty tablets of oxycodone 5 mg. --Twenty-nine tablets of lorazepam 0.5 mg. --Thirty tablets of Tramadol 50 mg. --Twenty-eight tablets of zolpidem 5 mg. --Fifteen mls of morphine sulfate 100 mg/5 ml. *There was no documentation of the above medications being counted at change of shift. Interview on 7/21/21 at 3:20 p.m. registered nurse (RN) B revealed: *The nurses do not count the controlled medications that are waiting to be destroyed. *The normal procedure when a controlled medication is awaiting destruction is to lock in the medication room cupboard. *Agreed that all nurses did have access to the a key to unlock that cupboard. *Agreed there had been no accountability for the controlled medications locked in the medication room cupboard. Interview on 7/21/21 at 3:25 p.m. with director of nursing (DON) A revealed: *She expected the controlled medications waiting to be destroyed to be locked in the lock box on the assisted living medication cart. *She was the only one who had a key to that lock box so if they were in that lock box then the medications would not have to be counted at change of shift. *She did not know there had been controlled medications in the medication room waiting to be destroyed. *She was going to move them down to the assisted living medication cart. *All controlled medications were destroyed by a nurse and a pharmacist when the pharmacist	F 755		

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 07/22/2021

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 755	Continued From page 13 came to the facility. Review of the provider's revised June 2020 Controlled and Scheduled Medications policy revealed: *"4. Controlled medications that residents are currently receiving and controlled medications held for future use will be counted at the beginning of each shift by a nurse coming on duty and a nurse going off duty. *5. The controlled medications that have been discontinued will be stored in the locked medication room in a locked drawer that only the Pharmacy Consultant and the Director of Nursing have a key for."	F 755		

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 _____	07/22/2021

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
E 000	Initial Comments Surveyor: 16385 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 7/19/21 through 7/22/21. Sun Dial Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erin Wattier
TITLE: Director or Nursing
(X6) DATE: 08/05/2021

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** B. WING _____	**07/21/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/21/21. 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

Erin Wattier | Director of Nursing | 08/05/2021

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 _____	07/22/2021

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 Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/19/21 through 7/22/21. Sun Dial Manor was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 16385 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 7/19/21 through 7/22/21. Sun Dial Manor was found in compliance.	S 000		

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

Erin Wattier

TITLE

Director of Nursing

(X6) DATE

08/05/2021