

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 01/29/2026
NAME OF PROVIDER OR SUPPLIER Sun Dial Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 410 Second Street Bristol, SD 57219	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported intake (FRI) review, interview, record review, and policy review, the provider failed to ensure an investigation was completed and documented for four of five resident elopements (leaving the facility without staff knowledge) after one of one resident (2) eloped on 11/22/25, 11/29/25, 12/4/25, and 1/1/26. Findings include: 1. Review of the provider's SD DOH FRIs regarding resident 2 revealed that the resident eloped from the facility on 11/22/25, 11/29/25, 12/4/25, and 1/1/26. On 11/22/25, resident 2 exited the building when another family was entering the building at around 4:20 p.m. Resident 2 was outside for less than 10 minutes. The report indicated that witness reports are being obtained. After that incident, the provider implemented a walking schedule with resident 2 so she could go outside every day with supervision. On 11/29/25 at around 6:38 a.m., resident 2 exited the building and walked towards the driveway. The door alarmed as intended, and staff were able to find resident 2 immediately and brought her back inside. She was outside for less than a minute. That report did not include investigation actions such as obtaining witness reports from staff or family who were present at the time of the elopement. On 12/4/25 at around 12:35 p.m., resident 2 was let out of the building by a resident who resided at the attached assisted living center (ALC). The report indicated that resident 2 was found outside by staff on the east side of the building[,] walking with another resident. The report did not specify which staff member found resident 2. The report did not include investigation actions such as interviewing the staff who found resident 2. On 1/1/26 at around 4:50 a.m., licensed practical nurse (LPN) K and certified nursing assistant (CNA) L heard the front door alarm. They went outside as they noticed resident 2's room door was open. They did not find resident 2 in their initial search. LPN K went back inside to call emergency services, while CNA L continued to look outside for resident 2. CNA L located resident 2 while LPN K was still on the phone with emergency services. Resident 2 was assessed. No injuries were found, and her vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were within normal limits. The report did not include investigation actions such as obtaining witness reports from LPN K or CNA L. 2. Interview on 1/28/26 at 1:36 p.m. with administrator A revealed that resident 2 discharged to a secure memory care facility and no longer resided in the facility. 3. Review of the provider's investigation records for resident 2's elopement on 11/22/25 revealed that staff witness statements were obtained from CNAs M and N on 11/22/25. CNA M mentioned in her witness statement that [Resident who resided on the East Wing] had family put call light on to let us know that [resident 2] got outside. Used [radio] to let others know. There was no documentation that the resident's family was interviewed regarding what they witnessed. There were no additional investigation materials other than what was included in the FRI. Review of the provider's investigation records for resident 2's elopement on 11/29/25 revealed that there were no witness statements gathered from staff. After the elopement, staff have created a monitoring form that documents the time when [resident 2] is exit seeking, attempting to discover a pattern of when she is</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>exit seeking the most. Interim director of nursing (IDON) B spoke with resident 2's power of attorney (POA), however, and learned that this was an issue at the previous facility [resident 2] was at, when referring to the resident's exit-seeking behaviors. There was no evidence to support other factors were investigated, such as changes in mood or medications, or other correlations. Review of the provider's investigation records for resident 2's elopement on 12/4/25 revealed that there were no witness statements gathered from staff or others present that day, including the staff member who found resident 2 outside. The provider's FRI included that the ALC resident was educated about not letting the nursing home residents outside without a staff member present. On 12/9/25, the provider conducted a root cause analysis to determine any factors that could have been contributing to resident 2's elopements. She was seen by a psychiatric provider related to the elopements and was started on escitalopram (an antidepressant) on 12/10/25, and Memantine (medication used to treat Alzheimer's disease) on 12/27/25. 15-minute checks were initiated on 12/4/25, where staff checked on resident 2's location every 15 minutes and documented what she was doing, where she was at, and what time she was observed. Review of the provider's investigation records for resident 2's elopement on 1/1/26 revealed that there were no witness statements gathered from staff present at the time of her elopement. The 15-minute checks continued, and the provider placed bells on her room doorknob to alert staff when she exited her room. 4. Interview on 1/29/26 at 9:28 a.m. with CNA G revealed that on 12/4/25, she was sitting in her car in the parking lot when she saw resident 2 and the ALC resident walking outside. She used her radio to let other staff know that resident 2 had gotten outside and helped her get back inside. She confirmed that she was not interviewed about the incident, and she did not write a witness statement regarding that incident. 5. Interview on 1/29/26 at 10:16 a.m. with administrator A and IDON B revealed that they did not have a formal investigation form. Their investigation consisted of progress notes in the electronic medical record (EMR) and the 15-minute checks. Registered nurse (RN) C completed the root cause analysis report after resident 2's 12/4/25 elopement, and they used that to adjust her interventions. 6. Interview on 1/29/26 at 10:42 a.m. with RN C revealed that she conducted staff interviews after resident 2's elopement on 11/22/25, and a different resident's elopement that happened in July 2025. She stated there was a witness statement form that they used when conducting investigations. She did not talk to the resident's family (the resident that resided on the East Wing) on 11/22/25 about resident 2's elopement that they witnessed. 7. Phone interview on 1/29/26 at 12:29 p.m. with CNA J revealed that she witnessed resident 2 exit the building on 12/4/25 when resident 2 walked out with an ALC resident. She helped coax resident 2 back inside. She confirmed she was not interviewed and did not write down a witness statement as part of an investigation regarding that incident. 8. Interview on 1/29/26 at 12:42 p.m. with IDON B revealed that she was not aware of any formal investigation process or that there were witness statement forms that were supposed to be used during an incident investigation. Based on her experience as a nurse, the normal investigation process was to at least document somewhere about where staff were at, who was in the building, what was going on. During that interview, administrator A entered the room and showed IDON B where the witness statements were located. 9. Interview on 1/29/26 at 1:41 p.m. with administrator A revealed IDON B started taking over the DON duties in October 2025. Administrator A expected the DON to conduct resident incident investigations. She confirmed that I am also supposed to oversee that it's followed through. She expected the DON to document the investigation, obtain all witness statements, and document as much information as possible. She confirmed that IDON B was not aware of the witness or investigation forms. She explained that they did not have a separate incident investigation policy, and that investigating incidents was part of the abuse and neglect prohibition</p> <p>(continued on next page)</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy. 10. Review of the provider's 9/9/24 Missing Resident Policy & Procedure revealed that part of the procedure read, An incident report shall be made by the charge nurse providing detailed accounting of the incident in its entirety. Submit to the state [SD DOH]. Place a copy on Administrator's desk or cc [carbon copy] in email. The policy also included the following, The charge nurse shall be responsible for documenting the incident in the nursing notes of the resident's chart. All documentation must be concise and reflect the facts as they relate to the incident including: a. Times, b. Persons contacted, c. Condition of resident upon return to the facility, d. Physician notification, e. Physician's orders, f. Treatment indicated, g. Any other pertinent information. 11. Review of the provider's June 2025 Abuse, Neglect, & Misappropriation policy revealed a section regarding investigations that included: 5. The Investigation Team will review all initial findings and will determine if further investigation is needed. The Investigation Team will notify the designated state agencies and complete any reports required. 6. The investigation may include interviewing staff, residents or other witnesses to the incident. Interview all involved (staff, resident and family) individually, not as a group, so that you can compare their descriptions of the incident in order to determine and inconsistencies. Any who had contact with the situation should be interviewed. 7. Corrective action based on the investigation(s) will be completed (e.g., change of procedures, training, discipline or discharge of staff, etc.).Sun Dial Manor shall have evidenced that all alleged violations are thoroughly investigated. The policy did not specify who was supposed to be on the Investigation Team.		