STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD , CHAMBERLAIN, South Dakota, 57325

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F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/14/26 through 7/16/26. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F554, F584, F645, F657, F695, F710, F759, F760, F812, F919. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/14/26 through 7/16/26. The areas surveyed included resident safety regarding the elopements of three residents. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F689.	F0000	The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
F0689 SS = E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to protect the safety of residents identified as at risk for elopement (leaving the facility without staff knowledge) when one of one sampled resident (22) crawled out a window, and two of two sampled residents (51 and 52) exited the facility without the staff's supervision.	F0689	1. Resident #22 sent to ER for evaluation. Upon return from the hospital, 15-minute checks were implemented to ensure safety. Careplan was updated to include to educate resident about the hazards of leaving during severe weather changes. To notify the police if resident elopes and unable to find or get resident to willingly come back to facility. Window handles were removed on 11/27/25, slide locks and chains were placed on the window on 12/1/25. Resident 51 was discharged from the facility AMA and no longer residents in the facility. Resident #52: was brought back to the facility assessed for injuries, none found. A wanderguard was placed on reisdent, and careplan was updated to indicate that resident is at risk for elopement and should be redirected by staff if showing wandering behaviors. Resident #30: new smoking assessment done on 8/3/26, and careplan updated that resident can smoke independently.	8/7/26

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F0689 SS = E	Continued from page 1 Findings include: 1. Review of the provider's 11/26/25 SD DOH FRI report regarding resident 22 revealed on 11/26/25 around 3:15 p.m., she was observed walking past the kitchenette window outside the building by cook P. Cook P immediately notified licensed practical nurse (LPN) K, who then went to verify resident 22 was not in her room. Upon entering resident 22's room, cook P noticed resident 22 window was open, and her window screen was off the window lying on the floor. Cook P went and notified long term care (LTC) activities G of the elopement, who then notified minimum data set (MDS) coordinator V and licensed social worker (LSW) U. LSW U, executive assistant (EA) E, MDS coordinator V, and LTC activities G exited the facility to search for resident 22. At 3:40 p.m., LTC activities G notified MDS Coordinator V that she had found resident 22 walking past a housing development and heading toward the Lutheran church, which was one block from the facility. LTC activities G remained with resident 22 who was wearing two sweaters, with a flannel long sleeve shirt, blue jeans, and tennis shoes. When MDS coordinator V and LSW U arrived at resident 22's location LTC activities G returned to the facility. Resident 22 became hostile towards MDS coordinator V and LSW U and resident 22 continued walking and they continued to follow her. The police were notified of resident 22's elopement at 3:26 p.m., and they arrived at the apartment complex and tried convincing resident 22 to return to the facility. Resident 22 refused the police officer's advise multiple times. MDS coordinator V called LPN K at 4:10 p.m. as she had a good rapport with resident 22 and asked for her assistance with resident 22. LPN K was able to convince resident 22 to get into her vehicle, and go to the emergency room (ER) to get assessed since resident 22 was outside in the cold. The outside temperature was in the upper 30s. While at the ER resident 22 had her alcohol level drawn, which was within normal limits. Former director of nursing (DON) C, executive director (ED) D, and resident 22's primary physician was notified of elopement and of the resident 22's condition. Resident 22 returned to the facility at 6:30 p.m. with LPN K after being discharged from the ER with no injuries or adverse side effects. MDS	F0689	2. all residents have the potential to be affected by the deficient practice if supervision and safety systems are not consistently implemented. To address this the facility assesses all new admissions for elopement risk and with any new exit seeking behaviors. All handles were removed from all windows to prevent further elopements, elopement drills occured on each shift for 5 days and then monthly therafter following the elopement of resident 22, and is the current process if an elopement does occur. The main entrance door is locked at all times, which started after resident # 52 incident. New smoking assess-ments completed for all current smokers and careplans have been updated. All smokers upon admission for safety and offered cessation support if warranted. Facility process changed to forbid residents that are elopement risks to smoke outside as of January 2026. 3. To ensure that residents remain free from accidents and hazards related to smoking and or elopement, elopement drills have been conducted on a monthly basis by DNS and will continue on an ongoing basis. Administrator or designee will conduct audits of the main entrance door being locked by random observations on a weekly basis x 4 weeks, and then monthly x 3 months. any negative findings will be brought to the QAPI committee for further review.	

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F0689 SS = E	Continued from page 2 coordinator V and former DON C initiated fifteen-minute visual checks on resident 22 to ensure her safety due to the cold weather and inability to get ahold of resident family members. Resident 22, they were to notify the Tribal Police and the facility so they could help 2. Review of resident 22's electronic medical record (EMR) revealed she was admitted to the facility on 9/24/21. Her diagnoses included epilepsy (a chronic neurological disorder characterized by recurrent, unprovoked seizures), anxiety disorder, borderline personality disorder (severe emotional instability, impulsive behaviors, and deeply unstable relationships) post-traumatic stress disorder (mental health condition triggered by experiencing or witnessing a terrifying or life-threatening event), bi-polar disorder (a mental health condition that causes extreme, cyclical shifts in mood, energy, and activity levels), alcohol abuse, and weakness. Her care plan indicated Behavioral symptoms focus of attempts to elopement at times from facility and on outings initiated on 8/13/25. With a goal of she will not elope from the facility or on outings until next review. Interventions initiated on 11/28/25 educate about hazards or leaving during severe weather changes (below 20 degrees, high heat temps, lightning, tornado warnings/watches, etc.) and understand risks if were to leave or elope from facility, her care plan identifies resident is not to be left at appointments due to her risk of leaving, and all outings need to be approved by her family. Educate her regarding outings with family, appointments etc. about signing out of facility, signing bed-hold policy, getting medications sent with if leaving with family. Notify Chamberlain PD if resident elopes and unable to find or get her to willingly come back to facility. Will become hostile at times when approached and does not want to come back to facility. Take to ER as needed for evaluation if questioning intoxication, injuries, or other health issues per police department or MD [medical doctor] recommendations. 3. Observation and interview on 7/15/26 at 12:28 p.m. with resident 22 in her room regarding her elopement revealed she was upset on 11/26/25 when she removed the screen from the window in her old room, opened the window, and climbed out of the window. The facility had removed the window handles a day or so after her elopement to prevent her from opening the window. Her current room had no window handles on the window, and the lock on the window frame was not locked. The window was	F0689		

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F0689 SS = E	Continued from page 3 tall and could open outwards away from the building. 4. Interview on 7/15/26 at 3:30 p.m. with cook P regarding resident 22's elopement revealed he was standing in the kitchenette doing dishes and he observed resident 22 walk past the window outside wearing a red checkered coat. He notified LPN K of the resident being outside. LPN K did not think that resident 22 was outside. Cook P went to the activities room at the end of the hallway and observed resident 22 walking on the road. When he walked past resident 22's room the window screen was out of the window, and the window was open. 5. Interview on 7/16/26 at 7:17 a.m. with LTC activities G regarding resident 22's elopement revealed twenty minutes before resident 22's elopement, she had delivered mail to resident 22, and she was in a good mood and had no complaints. LPN K notified all staff in the front of the building of resident 22's elopement on 11/26/25. Resident 22's window and all other window handles were removed after resident 22's elopement. 6. Interview on 7/16/26 at 7:29 a.m. with EA E regarding resident 22's elopement revealed she and LSW U took vehicles out to look for resident 22 following her elopement and law enforcement was notified. LTC activities G had located resident 22 by the church and resident 22 had refused to come back to the facility. EA E returned to the facility and asked LPN K to help get resident 22 to return to the building. EA E did not complete any education following resident 22's elopement. 7. Interview on 7/16/26 at 7:40 a.m. with LSW U revealed a staff member who she could not recall had notified her of resident 22's elopement. Resident 22 was found by the church and LSW U who had been out looking for her, encouraged resident 22 to return to the facility. She remained with resident 22 outside the church until resident 22 was taken to the ER. She was unsure if the window handles were still on resident 22's window when she eloped on 11/26/25. LSW U was working on a referral for resident 22 to be transferred to a different facility that could meet her needs. LSW U received education regarding the elopement policy following resident 22's elopement.	F0689		

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F0689 SS = E	Continued from page 4 8. Interview on 7/16/26 at 9:33 a.m. with MDS coordinator V regarding resident 22's elopement revealed resident 22 had exited out her window on 11/26/25 and MDS coordinator V searched the surrounding area in her vehicle for resident 22. She received a call from LTC activities G that resident 22 was found and refused to return to the facility. LPN K came and convinced resident 22 to go to the ER, where she was evaluated. Following resident 22's elopement, the facility added chains and a lock block to resident 22's window so the window could only open so far. She was unsure if the window handle was on resident 22's window at the time of her elopement. The facility started 15-minute visual checks on resident 22 after her elopement, but MDS coordinator V was unsure when those ended. She thought the staff working on 11/26/25 were educated that day on elopements and the facility's procedures if they occurred. She completed the elopement education in February of 2026. 9. Interview on 7/16/26 at 10:25 a.m. with LPN K regarding resident 22's elopement revealed she drove to the site where resident 22 was located on 11/26/25. LPN K helped resident 22 calm down and offered her a ride in LPN K's vehicle to the ER to be evaluated. She remained with resident 22 until she was discharged from the ER and back at the facility. Resident 22 had calmed down by the time she returned to the facility. Resident 22 was wearing a hooded sweatshirt, jeans, a T-shirt, shoes and socks. Resident 22 never complained of being cold that day. LPN K thought the facility had provided education regarding elopements following the incident. Resident 22 was receiving behavioral health services. Resident 22 can be delusional at times. Resident 22 does not understand her diagnoses and how serious they are. Resident 22 was placed on 15-minute visual checks after her return to the facility for a couple days, maybe longer. The facility put slide locks on resident 22's windows after resident 22's elopement. 10. Review of the provider's 9/5/25 SD DOH FRI report regarding resident 51 revealed on 9/5/25 at 8:04 p.m., registered nurse (RN) W received a phone call that an elderly person was walking with a cane near the road. RN W notified the former director of nursing (DON) C at 8:05 p.m. that resident 51 had "possibly" eloped when he was let out of the facility	F0689		

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F0689 SS = E	Continued from page 5 by a certified nursing assistant (CNA) to smoke. Former DON C and licensed social worker (LSW) U arrived at the facility and initiated the facility's elopement protocol immediately after RN W called. The staff searched all the rooms within the facility and the surrounding area. The police were notified that resident 51 was missing and began searching within several miles of the facility. Minimum Data Set (MDS) coordinator V contacted resident 51's emergency contact, who verified that resident 51 was at a family member's house and was safe. The emergency contact informed MDS coordinator V that the family member would bring resident 51 back to the facility the following day, 9/6/25. The resident was not dropped off on 9/6/25, and neither the family member nor the resident contacted the facility. On 9/7/25, former DON C and LSW U identified that resident 51 was still absent, and they, along with LPN O, attempted to call his emergency contact and family member multiple times. After multiple failed attempts, former DON C and LSW U advised LPN O to call the Lower Brule Tribal police to request a welfare check on resident 51 at his family member's residence. Resident 51's family member called the facility and informed LPN O that on 9/5/25, resident 51 had gone outside to smoke and had left. He did not tell the family member where he was going, and they did not have any way of contacting him. Adult Protection Services (APS) and case workers were informed on 9/8/25 of resident 51's elopement and his last known location, and the case workers told the facility that if they found resident 51, they would advise him to sign an against medical advice (AMA) form if he did not want to return to the facility. Resident 51 never returned to the facility. The facility updated resident 51's care plan (personalized plan that addresses a resident's care needs, goals, and interventions) to reflect he was an elopement risk and limited all residents' smoking time to 15 minutes while they were outside. The staff would monitor the residents while they were outside to smoke at designated smoking times set at 9:00 am, 2:00 p.m., and 7:00 p.m. The staff were educated regarding the facility changes, the provider's policy was updated, and the facility was going to improve the video surveillance on the sidewalk where the residents smoked. LSW U updated all the residents' assessments who were an elopement risk, and former DON C or the designee would audit the smoking times three times a week for six weeks.	F0689		

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F0689 SS = E	Continued from page 6 11. Review of resident's electronic medical record (EMR) revealed he was admitted to the facility on 8/14/25. His 8/20/25 BIMS assessment score was 9, which indicated his cognition was moderately impaired. His diagnoses included nicotine dependence and alcohol use. His undated care plan indicated that on 8/15/25, resident 51 was evaluated and approved to go outside unsupervised to smoke and agreed to follow the facility's safe smoking policy. He was allowed to keep cigarettes in his room. On 9/7/25, interventions were added that he had the potential to elope from the facility and was not to leave the facility unattended. The staff were to redirect him when he attempted to go out of the facility doors and remind him that before he left with family, he should inform the nurse. His 8/14/25 physician's order indicated that he was allowed to smoke in the early morning at 7 a.m. and to monitor him for an elopement risk. His 9/28/25 completed elopement assessment indicated that he had an elopement on 9/5/25 and did not present the resident as an elopement risk. 12. Observation on 7/14/26 at 2:14 p.m. of the smoking area revealed resident 30 was outside, sitting in his wheelchair smoking on the sidewalk by the street. No staff were present outside of the building. 13. Observation on 7/14/26 at 2:24 p.m. resident 30 self-propelled his wheelchair to the facility door at the end of Hamilton hallway and pressed a doorbell to be allowed back into the facility. There was a sign on the facility door indicating the allowed smoking times for the residents were 9:00-9:15 a.m., 2:00-2:15 p.m., and 7:00-7:15 p.m. The sign also said, "Please remember, residents must be observed by a staff member at all times while they are outside smoking. Please remember to offer the smoke apron as well." 14. Observation on 7/14/26 at 2:25 p.m. revealed that there were two video surveillance camera images on a monitor at the nurses' station. Neither image showed the street where the residents go to smoke or the facility door where resident 30 was at. CNA M let resident 30 back into the facility through the door. No staff entered with the resident from outside.	F0689		

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F0689 SS = E	Continued from page 7 15. Interview on 7/14/26 at 2:28 p.m. with CNA M revealed that the process for residents who smoke was that they have a couple of residents who go out and smoke when they want to, and the residents just let the staff know when they are ready to come back in by using the doorbell. The door was locked from the outside. "The staff does not have to watch them. There are times the residents are supposed to go out for a smoke, but they tell the staff when they want to go, and we let them out." 16. Review of resident 30's EMR revealed he was admitted to the facility on 2/19/26. His 5/15/26 BIMS assessment score was 10, which indicated his cognition was moderately impaired. His diagnoses included cerebral palsy (a neurological disorder that permanently affects a person's ability to move, maintain balance, and sustain posture) and anxiety disorder. His 4/13/26 smoking assessment indicated he was able to take himself out to the designated smoking area. He could safely light his own cigarette and smoke the entirety of the cigarette without causing injury to himself. He was able to put out the cigarette and dispose of the cigarette butt in the designated trash can. His care plan did not indicate he smoked, that a smoking assessment was completed, or that he was safe to smoke independently. 17. Observation on 7/15/26 at 12:41 p.m. of the designated smoking area revealed resident 30 was out smoking on the sidewalk with no staff outside monitoring him. 18. Interview on 7/16/26 at 1:21 p.m. with DON B revealed LSW U completed the resident's elopement risk assessments upon admission. If a resident smoked, the resident was offered nicotine patches, and a physician's order would be requested. If a resident was identified as an elopement risk and someone who smoked, they were not able to go outside since January 2026. The designated smoking times were 9:00 a.m., 2:00 p.m., and 7:00 p.m., and were to be used by the residents who currently reside in the facility. The residents were allotted 15 minutes to smoke, but the current residents who smoke did not have to be monitored since they did not exhibit any concerns. The staff monitored smoking residents on a case-by-case basis. There were no cameras installed that viewed the designated smoking area.	F0689		

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F0689 SS = E	Continued from page 8 19. Review of the provider's 9/9/25 smoking education revealed that the staff was educated that there were designated smoking times at 9:00 a.m., 2:00 p.m., and 7:00 p.m., effective immediately. These times were not optional and must be abided by all staff and residents. The residents would be limited to 15 minutes for each smoking session and must be observed by a staff member for the entire 15 minutes. Observation by the staff was required. Before a resident was allowed to go out to smoke, they were to be screened/assessed by former DON C or MDS coordinator V. The residents must be offered the smoke apron when they go out to smoke, and they were to smoke off the facility property, near the sidewalk by the road. When a resident was let out to smoke, the staff were to communicate who was going to monitor that resident. The education included the facility's smoking procedure and policy. indicated that 51 out of 60 nurses, CNAs, and certified medication assistants (CMAs) completed the education in person or by phone. 20. Review of the provider's reviewed 1/16/25 Safe Smoking Assessment revealed "Purpose to provide an assessment to assess resident safety with smoking or tobacco use. To have a protocol for assessment and re-assessment. Each resident upon admission will be asked if they wish to smoke (including electronic cigarettes) or use tobacco products while a resident in long-term care. If the resident chooses to smoke, the following will occur: an assessment for safety while using tobacco products will be completed by occupational therapy or designated staff upon admission. Following the assessment the interdisciplinary team (IDT) will collaborate on the findings of the assessment and determine the recommendations for safety use of tobacco use. Resident and/or representative will be notified of final recommendations. Staff will be notified of the recommendations. A re-assessment will be completed on a quarterly and as needed basis (change of condition, non-compliance, safety issues identified) for continued assessment of safety with smoking or use of tobacco products. Ongoing monitoring by staff will occur as to the resident's ability to safely [safe] handle tobacco products and paraphernalia." 21. Review of the provider's 2/5/26 SD DOH FRI report regarding resident 52 revealed that on 2/5/26 at 2:12 p.m., executive director D found resident 52 outside, 75 feet from the main entrance of the	F0689		

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F0689 SS = E	Continued from page 9 facility. The outside temperature was 60 degrees and sunny with no wind. Resident 52 was wearing a long-sleeved shirt, pants, socks, and shoes. He did not have any injuries. He was not previously identified as an elopement risk and was not assigned a WanderGuard (a wearable door alarming device). Resident 52 was brought inside the facility where RN X took his vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate), which were all within normal range, and put a WanderGuard on him. His care plan (a personalized plan that addresses a resident's care needs, goals, and interventions) was updated to indicate he was at risk for elopement and should be redirected by the staff if they found him wandering the facility. The facility's investigation indicated that at the time of resident 52's elopement, the main entrance door was unlocked and not alarmed. Following resident 52's elopement, the main entrance door was to be locked at all times and would alarm when opened. Visitors could call the nurse's station if they needed to enter the building. The staff were reeducated about the facility's elopement procedures and LSW W and DON B held elopement drills on each scheduled shift for five days and then monthly and conducted audits for eight weeks verifying that the facility's main entrance doors remained locked. 22. Observation on 7/15/26 at 8:00 a.m. revealed a sign on the main entrance door indicating the door was locked and that visitors should call the nurse's station to be let into the building. 23. A review of resident 52's electronic medical record (EMR) revealed he was admitted to the facility on 12/15/25. He had a diagnosis of a neurocognitive disorder with Lewy bodies dementia (a progressive type of dementia affecting memory, thinking, and social abilities, characterized by severe fluctuations in alertness and visual hallucinations. His Brief Interview for Mental Status (BIMS) assessment score was 3, which indicated his cognition was severely impaired. His 2/5/26 care plan indicated he displayed confusion, forgetfulness, and restlessness. The staff should redirect him when he displayed wandering behaviors and remove him from other residents' rooms and unsafe situations. He required	F0689		

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F0689 SS = E	Continued from page 10 the staff's assistance with a gait belt (a waist strap gripped as support for safe mobility and transfers) when ambulating (walking) and supervision when he independently used his wheelchair or walker. His locomotion approach in the care plan read, "Needs supervision around facility due to [being a] high fall risk and elopement risk." 24. Interview on 7/16/26 at 9:30 a.m. with administrator A confirmed that when resident 52 eloped on 2/5/26, he was not wearing a WanderGuard and was not considered an elopement risk. "He hadn't displayed exit-seeking behavior, and he wasn't walking up and down the hall," she said. She expected that for any residents displaying exit-seeking behaviors, the resident would have been assessed for eloping and have a WanderGuard in place. The staff who observed exit-seeking or wandering behavior should walk with the residents to ensure they are safe, and redirect or distract them by offering an activity, a snack, or a one-to-one visit. 25. Interview on 7/16/26 at 9:38 a.m. with DON B revealed that three of the 42 residents wore WanderGuards. If the residents were observed wandering or trying to leave the building, she expected the staff to redirect them to a purposeful activity. She said resident 52 had worked in the construction industry, "so an activity surrounding that which he would enjoy, or something else to capture his interest." 26. Interview on 7/16/26 at 9:48 a.m. with certified nursing assistant (CNA) I revealed that she expected the staff to follow residents who were seen wandering the facility, to talk to them and to "redirect them back to coffee or try to engage them in an activity, something they would enjoy." 27. Review of the provider's elopement drill documentation revealed that following resident 52's elopement, 10 drills were conducted in February, followed by five monthly drills held from March through July. For each drill, the staff responded by following elopement drill policies and procedures. DON B documented that the front door was checked 40 times from 2/9/26 through 4/3/26, and each time it was found to be locked and alarmed. 28. Review of the provider's All Staff Meeting notes	F0689		

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F0689 SS = E	Continued from page 11 from 2/17/26 and 2/18/26 indicated that 18 of the 61 staff members attended the meeting, which included a review of the provider's elopement policy and procedures, and that "anybody not in attendance was mailed a copy of the elopement policy" on 2/20/26. 29. Review of the provider's 7/15/25 Security Alert: Missing Person-Elopement policy revealed that after a resident eloped from the facility, the resident's care plan would be updated to reflect the elopement and to include "an appropriate plan of treatment" and an elopement prevention plan. The policy indicated the facility's care planning team was responsible for preventing elopements and ensuring the safety of all residents. 30. Review of the provider's 7/15/25 Security Alert: Missing Person-Elopement policy revealed: To protect [a] resident from potential harm by identifying a process to follow when a resident is observed eloping from facility. To protect [a] resident from potential harm by identifying a process to follow when a resident has eloped from the facility. When it is determined a resident's whereabouts are unknown the procedure for elopements will be activated immediately. Any staff member observing an identified wandering resident attempting to leave the facility shall attempt to prevent such a departure. Should the attempt fail, the staff member shall obtain the assistance of other staff members in the immediate vicinity. If none are available, the staff member shall immediately notify administration or the nursing staff that the resident has left the premises and then return quickly to the resident and continue attempting redirect the resident safely back into the building. Staff members are not to leave the resident for any reason if the resident's safety is in immediate danger. A second staff member will assist in escorting resident back to the facility if first staff member is unsuccessful or may call the local law enforcement as the situation warrants.	F0689		
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F0759	1 For resident 36 , who did not recieve the full dose of insulin, the charge nurse received education from the DNS on 7/16/25 regarding porper insulin administration technique and the requirement to notify the doctor if a complete dose was not administered. For resident 38 who did not receive the ordered medication due to incorrect labeling on the medication card, education will be provided by the DNS to all CMA's and nurses of the medication administration policy and the requirements to notify the pharmacyif medication labeling does not match the doctor's order. For resident 24 & 37 education will be provided by the DNS to all Nurse's and CMA's of the the self administration medication policy. Resident 37 received a doctor's order to self administrator nebulizer after set up from nurse/cma on 8/7/26.Resident 24 is not safe to self administer oral medications. Education was provided by the DNS to all CMA nurses to not leave oral medications at the bedside.2.all residents with orders for self administration of medications were reviewed to verily an order was active and a self administration assessment was completed.	8/18/26

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F0759 SS = E	Continued from page 12 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent related to resident (36) no receiving her full dose of insulin, resident (38) not receiving her calcium/vitamin D/vitamin K due to incorrect labeling, residents (24 and 37) self-administering a medication with no assessment or orders from the physician. Those observed errors resulted in a medication error rate of 14.29%. Findings include: 1. Observation on 7/15/26 at 11:30 a.m. certified medication assistant (CMA) N left Seroquel (an antipsychotic medication) (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), 50 mg, 1 tab in a medicine cup on resident 24's bedside table to the left of her bed and did not watch her take the medication. 2. Observation on 7/15/26 at 11:33 a.m. CMA N put Ipratropium-Albuterol 0.5 milligrams (mg)-3mg/3 milliliter (mL) 1 vial liquid nebulizer medication into the nebulizer machine for resident 37 and then left the room after the machine was turned on by resident 37. 3. Review of resident 24's electronic medical record (EMR) indicated she admitted to the facility on 7/14/20. Her 7/3/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. Her medication administration record (MAR) indicated she had a physician's order dated 6/25/24 for Seroquel 50 mg, 1 tab by mouth once a day at 12:00 p.m. There were no special instructions noted on this order to indicate that this medication was to be self-administered. Her diagnoses include anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder (PTSD) (is a mental health condition that can develop after a person experiences or witnesses a traumatic event), epilepsy (s a chronic brain disorder characterized by two or more unprovoked seizures that are sudden bursts of abnormal electrical activity in the brain that can cause temporary changes in behavior, muscle control, awareness, or sensations), weakness, and	F0759	3. The DNS will provide education to all nurses and CMA's on 8/18/26 regarding medication administration procedures, insulin administration, self administration of medication policy, and the requirements of a doctor's order and assessment prior to any self administration. Resident's that self administer any medications are assessed quarterly and prn to ensure safe to continue. DNS or designee will do medication administration competencies and insulin administration competencies on all cma's and nurses on 8/18/26. 4. The DNS or designee will complete medication administration audits, including insulin administration, on 3 residents weekly for for weeks and monthly for 3 months or until complaince is met. Audits verifying that no oral medcaitons are left at the bedside will be completed weekly x 4 weeks. The MDS coordinator or designee will audit all residents approved for self administration monthly for 3 months to ensure current doctor orders are present and assessments are current. any negative findings will be brought to the QAPI committee for review.	

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F0759 SS = E	Continued from page 13 chronic pain. She had a physician's order dated 10/13/25 that indicated that resident 24 may self-administer Triamcinolone Acetonide Cream (TAC) (a topical corticosteroid used to treat skin inflammation and itching), Lidocaine cream, TUCKS pads (pre-moistened medicated cooling pads relieves irritation, itching, burning and swelling), Estradiol cream (a prescription topical estrogen used to treat vaginal and genitourinary symptoms caused by low estrogen levels), Nystatin powder (a topical antifungal medication used to treat skin and mucous membrane infections caused by yeast), and Flonase (a corticosteroid that reduces inflammation in the nasal passages). Her 4/23/26 self -administration of medication assessment indicated the list of medications the resident would like to self-administer included TAC cream, Lidocaine cream, TUCKS pads, Estradiol cream, Nystatin powder, and Flonase. In this assessment, resident 24 voiced that she did not want to administer pill forms as she might spill, drop, or mess up. She had some difficulties with the use of her left arm d/t ROM limitations and a weak hand grip. 4. Review of resident 37's EMR indicated he admitted to the facility on 5/10/2012. His 6/12/26 BIMS assessment score was 15, which indicated his cognition was intact. His MAR indicated a physician's order dated 5/11/2026 for Ipratropium-Albuterol solution for nebulization 0.5 mg-3 mg/ 3 ml, 1 unit dose inhaled 5 times per day. There were no special instructions on this order to indicate that this medication was to be self-administered. His diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), hemiplegia affecting right dominant side (paralysis affecting one side of the body), presbyopia (loss of near vision), emphysema (a chronic lung condition and a form of COPD caused by gradual damage to the alveoli, the tiny air sacs responsible for gas exchange), dysphagia (difficulty swallowing, which may involve trouble getting food or liquids from your mouth to stomach), and aphasia (a language disorder that affects the ability to speak, understand, read, or write). He had a physician's order dated 9/29/2015 that indicated resident 37 may self-administer Refresh	F0759		

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=0759 3S = E	Continued from page 14 Optive eye drops. He had a physician's order dated 10/7/2015 that indicated her may self-administer ProAir Hydrofluoroalkane (HFA) inhaler (a pressurized canister that contains medication mixed with liquid HFA, a propellant used in modern metered-dose inhalers). 5. Observation on 7/15/26 at 12:03 p.m. of registered nurse (RN) J administering Novolog FlexPen (insulin aspart, a rapid-acting insulin in a prefilled pen. A needle attaches to the pen for medication administration) to resident 36. The ordered dose was 5 units (u). RN J injected the insulin into the resident's abdomen by pressing the medication dial at the end of the FlexPen. One second was counted from the start of the administration (when the pen is placed against the resident's stomach and the metered dose dial is pressed down) to the time the insulin pen was removed. She removed the pen from the resident's abdomen prior to the medication being fully dispensed into the resident's abdomen, as evidenced by when she pulled the insulin pen away from the resident; the insulin then expelled out of the needle onto the resident's skin. 6. Review of resident 36's electronic medical record (EMR) indicated she admitted to the facility on 9/3/25. Her 5/29/26 BIMS assessment score was 10, which indicated her cognition was moderately impaired. Her MAR indicated a 4/15/24 physician's order for Novolog FlexPen U-100 Insulin (insulin aspart U-100) 100unit/3mL, give 5 units subcutaneously with meals at 8:30 a.m., 12:00 p.m., and 5:30 p.m. Her diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar that causes damage to multiple peripheral nerves, usually leading to pain, numbness, or tingling in the hands and feet), chronic kidney disease stage 3 (moderate kidney damage indicating reduced kidney function), hypo-osmolality (low concentration of particles in the blood, usually from having too much water compared to electrolytes), and hyponatremia (sodium levels are low in the blood), chronic systolic (congestive) heart failure (a long-term condition where the heart's left ventricle weakens and can't pump blood effectively, leading to fluid buildup in the body), rheumatic mitral stenosis (a narrowing of the mitral valve caused by rheumatic fever, which restricts blood flow from the left atrium to the left ventricle and can lead to breathing difficulty and fatigue), nonrheumatic mitral insufficiency (also called mitral regurgitation, is when the mitral valve	F0759		

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F0759 SS = E	Continued from page 15 doesn't close properly allowing blood to leak backward from the left ventricle into the left atrium), and pulmonary hypertension (high blood pressure in the arteries that carry blood from the right side of the heart into the lungs, usually caused by narrowed or blocked lung vessels). 7. Interview on 7/15/26 at 3:16 p.m. with CMA N revealed that she did not usually leave medications with residents, but if she did, then they should have a self-administer order. She did not know how to tell if a resident had a self-administer order on the MAR or if there was another place to look. If she did not know what to do, she looked at the previous worker's documentation to see what she should do. 8. Interview on 7/15/26 at 4:28 p.m. with RN J revealed her process for insulin administration was that she would wait three seconds before removing the insulin pen from the resident to ensure the resident receives the full dose. She agreed that if the insulin was expelled onto the resident's skin when removing the needle from the injection site, the resident did not get her full ordered dose. RN J stated that if the resident did not get her full dose, she would tell the director of nursing (DON), monitor the patient, and notify the provider. 9. Observation on 7/16/26 at 7:42 a.m. of CMA H during medication pass for resident 38 revealed two medication blister packs (a card with medications sealed in individual plastic bubbles) for the morning dose for LDR Vit C600+D3/MINS CHEW 60 EACH. Generic for LDR VIT C600+D3/MINS CHEW CENTURY, each containing one-half tab. CMA H prepared to give the morning dose by removing each half tab from the medication blister packs into a separate paper cup. 10. Interview and EMR review on 7/16/26 at 7:50 a.m. with CMA H revealed a physician's order for Calcium 500 milligram (mg)-Vitamin D3 1000 u – Vitamin K 40 micrograms (mcg) chewable tablet 1 tab twice a day. CMA H acknowledged that the medication blister pack label and the physicians' orders in the EMR did not match. CMA H stated that she did not know the process for reporting that type of error, but "I can tell the nurse or the DON. When we complete the medication card changeover to the new packs, the staff are supposed to double-check they match the MAR and previous cards." 11. Interview on 7/16/26 at 7:56 a.m. with DON B revealed that she expected the medication cards would match the physicians' order on the MAR.	F0759		

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F0759 SS = E	Continued from page 16 12. Review of resident 38's EMR indicated she admitted to the facility on 10/22/25. Her 4/17/26 BIMS assessment score was 12, which indicated her cognition was moderately impaired. Her diagnoses included weakness, age-related osteoporosis (a condition where bones become thin, weak, and more likely to break easily) without current pathological fracture, and chronic kidney disease stage 3 moderate kidney damage (indicating reduced kidney function). 13. Interview on 7/16/26 at 1:21 p.m. with the DON B revealed she expected the residents to have a self-administration assessment completed by the minimum data set (MDS) coordinator V and an order from the residents' primary care provider before leaving the medications with the residents to self-administer. The orders for self-administration for the CMA's and nurses to see would be listed under the special instructions under each medication. DON B confirmed that residents 24 and 37 did not have self-medication administration orders for the observed Seroquel and Ipratropium-Albuterol nebulizer medications. She expected that the staff would stay with the residents until the medication was taken completely. She stated that a resident not receiving their full ordered dose of insulin, the resident's physician not being notified, and the lack of increased monitoring for resident 36 after the medication error were considered a significant medication error. 14. Interview on 7/16/26 at 3:15 p.m. with DON B revealed that the label on the medication blister pack was incorrect for resident 38's calcium/vitamin D/vitamin K order. She expected the medication to have the correct label on it. 15. Observation on 7/16/26 at 3:25 p.m. the medication blister packs for resident 38's calcium/vitamin D/vitamin K order were still in the medication cart. 16. Review of the provider's reviewed 3/2/26 Medication Errors policy revealed "the location will have medication error rates of five percent or less and those residents are free of significant medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident, and or responsible party and documented in the SAFE Event Reporting application. Definitions from the State Operations Manual Significant Medication Error one which causes the resident discomfort or jeopardizes his or her health and safety. Wrong Dose/Amount when	F0759		

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F0759 SS = E	Continued from page 17 the resident receives an amount of medication that is greater than or less than amount ordered by the prescriber." 17. Review of the provider's reviewed 10/31/25 Resident Self-Administration of Medication policy revealed "Purpose: to determine if the resident can safely self-administer medications. To identify which medications may be safely self-administered. Procedure: 1. Complete the resident self-administration of medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do so safely. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to self-administer medications(s). 3. The interdisciplinary team will also determine where medications will be stored. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self-administering. 5. The interdisciplinary team will determine who will document the medication administration." 18. Review of the provider's reviewed 3/30/26 Medication: Administration Including Scheduling and Medication Aides revealed "The resident has the right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Procedure: Follow the "Six Rights": right medication, right dose, right resident, right route, and right documentation. Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication."	F0759		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by:	F0554		

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F0554 SS = D	Continued from page 18 Based on observation, interview, record review, and policy review, the provider failed to ensure that evaluations for self-administration of medication were completed for two of two residents (24 and 37) whose medications were left at the bedside by CMA N. Findings include: 1. Observation on 7/15/26 at 11:30 a.m. certified medication assistant (CMA) N left Seroquel (an antipsychotic medication) (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), 50 mg, 1 tab in a medicine cup on resident 24's bedside table to the left of her bed and did not watch her take the medication. 2. Observation on 7/15/26 at 11:33 a.m. CMA N put Ipratropium-Albuterol 0.5 milligrams (mg)-3mg/3 milliliter (mL) 1 vial liquid nebulizer medication into the nebulizer machine for resident 37 and then left the room after the machine was turned on by resident 37. 3. Review of resident 24's electronic medical record (EMR) indicated she admitted to the facility on 7/14/20.bHer 7/3/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. Her medication administration record (MAR) indicated she had a physician's order dated 6/25/24 for Seroquel 50 mg, 1 tab by mouth once a day at 12:00 p.m. There were no special instructions noted on this order to indicate that this medication was to be self-administered. Her diagnoses include anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder (PTSD) (is a mental health condition that can develop after a person experiences or witnesses a traumatic event), epilepsy (s a chronic brain disorder characterized by two or more unprovoked seizures that are sudden bursts of abnormal electrical activity in the brain that can cause temporary changes in behavior, muscle control, awareness, or sensations), weakness, and chronic pain. She had a physician's order dated 10/13/25 that indicated that resident 24 may self-administer Triamcinolone Acetonide Cream (TAC) (a topical corticosteroid used to treat skin inflammation and	F0554	1. Education was provided by the DNS to CMA N on 7/29/26 to not leave any medication at the bedside of any resident. Education was provided by the DNS to all CMA's and Nurses on 8/3/26 to not leave any medications at the bedside of any residents. 2. MDS coordinator reviewed all residents that are approved to self administer medications to verify an active order was present and assessment to self administer was up to date. 3. Education on self administration of medication policy will be provided by the DNS on 8/18/26. 4.MDS coordinator will audit residents with self administration of medications orders monthly for 3 months, audit will include assessment is up to date, Doctor order is active,and medications approved for self administration are identified. any negative findings will be reviewed by the Qapi committee.	8/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD , CHAMBERLAIN, South Dakota, 57325

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F0554 SS = D	Continued from page 19 itching), Lidocaine cream, TUCKS pads (pre-moistened medicated cooling pads relieves irritation, itching, burning and swelling), Estradiol cream (a prescription topical estrogen used to treat vaginal and genitourinary symptoms caused by low estrogen levels), Nystatin powder (a topical antifungal medication used to treat skin and mucous membrane infections caused by yeast), and Flonase (a corticosteroid that reduces inflammation in the nasal passages). Her 4/23/26 self -administration of medication assessment indicated the list of medications the resident would like to self-administer included TAC cream, Lidocaine cream, TUCKS pads, Estradiol cream, Nystatin powder, and Flonase. In this assessment, resident 24 voiced that she did not want to administer pill forms as she might spill, drop, or mess up. She had some difficulties with the use of her left arm d/t ROM limitations and a weak hand grip. 4. Review of resident 37's EMR indicated he admitted to the facility on 5/10/2012. His 6/12/26 BIMS assessment score was 15, which indicated his cognition was intact. His MAR indicated a physician's order dated 5/11/2026 for Ipratropium-Albuterol solution for nebulization 0.5 mg-3 mg/ 3 ml, 1 unit dose inhaled 5 times per day. There were no special instructions on this order to indicate that this medication was to be self-administered. His diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), hemiplegia affecting right dominant side (paralysis affecting one side of the body), presbyopia (loss of near vision), emphysema (a chronic lung condition and a form of COPD caused by gradual damage to the alveoli, the tiny air sacs responsible for gas exchange), dysphagia (difficulty swallowing, which may involve trouble getting food or liquids from your mouth to stomach), and aphasia (a language disorder that affects the ability to speak, understand, read, or write). He had a physician's order dated 9/29/2015 that indicated resident 37 may self-administer Refresh Optive eye drops. He had a physician's order dated 10/7/2015 that indicated her may self-administer ProAir Hydrofluoroalkane (HFA) inhaler (a pressurized canister that contains medication mixed with liquid HFA, a propellant used in modern metered-dose inhalers).	F0554		

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F0554 SS = D	Continued from page 20 5. Interview on 7/15/26 at 3:16 p.m. with CMA N revealed that she did not usually leave medications with residents, but if she did, then they should have a self-administer order. She did not know how to tell if a resident had a self-administer order on the MAR or if there was another place to look. If she did not know what to do, she looked at the previous worker's documentation to see what she should do. 6. Interview on 7/16/26 at 1:21 p.m. with the DON B revealed she expected the residents to have a self-administration assessment completed by the minimum data set (MDS) coordinator V and an order from the residents' primary care provider before leaving the medications with the residents to self-administer. The orders for self-administration for the CMA's and nurses to see would be listed under the special instructions under each medication. DON B confirmed that residents 24 and 37 did not have self-medication administration orders for the observed Seroquel and Ipratropium-Albuterol nebulizer medications. She expected that the staff would stay with the residents until the medication was taken completely. 7. Review of the provider's reviewed 10/31/25 Resident Self-Administration of Medication policy revealed "Purpose to determine if the resident can safely self-administer medications. To identify which medications may be safely self-administered. Procedure: 1. Complete the resident self-administration of medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do so safely. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to self-administer medications(s). 3. The interdisciplinary team will also determine where medications will be stored. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self-administering. 5. The interdisciplinary team will determine who will document the medication administration." 8. Review of the provider's reviewed 3/30/26 Medication: Administration Including Scheduling and Medication Aides revealed "The resident has the right to self-administer medications if the	F0554		

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F0554 SS = D	Continued from page 21 interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Procedure: Follow the "Six Rights": right medication, right dose, right resident, right route, and right documentation. Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe, and just before administering the medication. Do not leave medication at the bedside or at the lable unless there is a specific physician order to do so, and the resident has been evaluated for self-administration."	F0554		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F0584	For resident 28, flooring the bathroom was repaired on 7/21/26. 2. Audits of all resident's rooms flooring was done on 8/4/26 by the DNS and EVS. 1 other room was found to be in of repairs to the flooring and has been scheduled for re-pairs. 3. Education was provided to all staff on 8/3/26 to report to their super-visor or administrator any uncleanable surfaces or damage to flooring. Monthly checks of the flooring was added to the maintanence preventive checklist. 4.EVS supervisor will audit resident room flooring monthly for 3 months to ensure no other flooring is damaged. any negative finding will be reviewed by the qapi committee.	8/18/26

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F0584 SS = D	Continued from page 22 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to maintain resident bathrooms in a clean and well-kept manner, free from damage to flooring, for one of one sampled resident (28). Findings include: 1. Observation on 7/14/26 at 8:46 a.m. in resident 28's bathroom revealed a gouge in the flooring near the wall, measuring approximately 12 inches long by one inch wide. The flooring curled up around the edges of the gouge causing an uneven surface. 2. Interview on 7/16/26 at 9:27 a.m. with interim administrator A revealed that she expected the staff to notify the director of nursing or maintenance staff of any damaged flooring in resident rooms. She considered torn bathroom flooring to be a fall hazard for both the residents and the staff, which made it a priority to repair. 3. Interview on 7/16/26 at 9:37 a.m. with director of nursing (DON) B revealed that she considered the torn flooring to be a fall hazard and an uncleanable surface (an area heavily damaged or corroded that traps bacteria in its crevices and cannot be adequately sanitized). She said repair of items that pose a safety hazard should be fixed right away. 4. Interview on 7/16/26 at 9:07 a.m. with plant operations supervisor (POS) F revealed that he did not know the flooring was torn in resident 28's bathroom. He agreed the torn flooring was an uncleanable surface and a fall hazard. He expected the housekeeping staff to notify him as they encountered such situations during daily bathroom cleaning. Any staff member could request	F0584		

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F0584 SS = D	Continued from page 23 maintenance repairs by submitting a Microsoft Teams "ticket," paging or calling him, or leaving him a handwritten note. POS F said the maintenance staff address repair requests as time allows, and resident room repairs are typically completed after a resident moves out of the room, before a new resident moves in. Urgent room repairs could be completed when residents were at an activity or a medical appointment, or the resident could temporarily relocate to a different room to avoid disruption of their routine. 5. Interview on 7/16/26 at 9:47 a.m. with certified nursing assistant (CNA) I revealed that she did not know the flooring was torn in resident 28's bathroom. She agreed it was a fall hazard that should have been reported to the maintenance team. "We could catch a lift [a mechanical device used to assist residents during transfers to the toilet or a wheelchair] on it, or the resident could catch their foot on it and fall." 6. Review of resident 28's electronic medical record (EMR) revealed she admitted to the facility on 8/30/23. She had a diagnosis of unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) and a 5/1/26 Brief Interview for Mental Status (BIMS) assessment score of three, indicating she had severe cognitive impairment. Resident 28's 5/8/26 care plan indicated she relied on assistance from two staff members to transfer to and from the toilet, bed, recliner, wheelchair, and bath chair. She used her feet to independently propel herself in her wheelchair but required staff assistance to travel longer distances. Her care plan revealed she had a history of falling and that the staff should keep her environment free of clutter. 7. Review of the provider's current Assets Resource Packet revealed that assets (capital and physical properties used for facility operations and resident care, categorized as land improvements, buildings, and fixed or movable equipment) should be repaired or replaced if their condition did not meet code or safety standards.	F0584		

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F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-	F0645	1.PASRR reviews for resident 2 and 22 were submitted for review by LSW on 7/16/26. 2. A review of all resident's PASRR's were done by the LSW and 2 other residents were identified to need a PASRR review completed and was submitted. 3. LSW has set up a process to ensure that PASRR's are reviewed submitted prior to expiration dates by setting up a process of having a reminder on a calendar to monitor PASRR expiration dates and review requirements. PASRR reviews will be completed quarterly with the MDS by the LSW or designee. 4. MDS coordinator or designee will do monthly audits of all new admissions for 3 months. any negative findings will be brought to the qapi committee for further review.	8/18/26

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F0645 SS = D	Continued from page 25 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (2 and 22) had a Preadmission Screening and Resident Review (PASRR) II completed. Findings Include: 1. Review of resident 22's electronic medical record (EMR) revealed she was admitted to the facility on 9/24/21. Her diagnoses included bipolar disorder, post-traumatic stress disorder (PTSD) and depression. Her 5/1/26 Brief Interview for Mental Status (BIMS) assessment score was 14 which indicated she was cognitively intact. She had a Department of Social Services (DSS) letter dated 1/18/22 which indicated she "had been approved for 365 days for admission or continued stay to a nursing facility effective as of the date of this letter. At that time, you may be appropriate for discharge to a lower level of care." As a result of the review, the following recommendations are made: Initiate mental health services-this may include psychiatric medication management and supportive therapy. A PASRR resident review was completed for resident 22 by licensed social worker (LSW) U on 7/10/24 for	F0645		

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F0645 SS = D	Continued from page 26 the facility on the screening form it was noted the end date of current PASRR was 1/18/23. The screening indicated resident 22 had serious mental illness of bipolar disorder, PTSD, and depression. She was referred to Maximus (a clinical service that evaluates individuals applying for or residing in Medicaid-certified nursing facilities) on 7/10/24 at 10:36 a.m. for resident review. Maximus notice dated 7/24/224 to LSW U indicated resident 22 PASRR Level I Review determination had expired. The letter stated the Level I screen expired because your health care professional did not complete the Level I screening form and/or submit requested documentation within the required timeframe. 2. Interview on 7/15/26 at 2:00 p.m. with LSW U revealed she completed the PASRR paperwork for the facility. She had received the PASRR expiration letter for resident 22 and had submitted a PASRR Level I review on 7/10/24. Resident 22 was referred to Maximus on 7/10/24 for a Level II review and she never received papers back from Maximus. Typically, Maximus sends the determination Level II letter to the facility (or to her) after the required information is sent to Maximus. 3. Follow-up interview on 7/16/26 at 7:48 a.m. with LSW U revealed she had heard back from Maximus and they want her to resubmit the Level I paperwork for resident 22 again. She is unsure why they did not receive the paperwork for resident 22 in 2024. She had not followed up on the letter. 4. Interview on 7/16/26 at 9:56 a.m. with director of nursing (DON) B revealed she would expect LSW U to complete and submit the PASRR Level I forms and resident reviews and take care of any recommendations made for the residents. 5. Review of resident 2's EMR revealed she admitted to the facility on 8/11/21. Her 6/19/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbances (a noticeable decline in cognitive abilities such as memory, attention, or problem-solving), psychotic disorder (a serious mental health condition characterized by a significant loss of contact with reality), unspecified disorder of adult personality and behavior (a mental health condition marked by enduring, inflexible patterns of thinking, feeling, and behaving that significantly deviate from cultural norms, cause distress or impair daily functioning), unspecified	F0645		

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F0645 SS = D	Continued from page 27 intellectual disabilities (significant limitations in intellectual functioning). She had a Department of Human Services (DHS) letter dated 10/23/23, which indicated she had been approved for continued staff-provided services by the facility for 120 days, effective 10/11/23. As a result of the review, the following recommendations were made: "Please continue with skilled therapy services and/or restorative nursing services as appropriate. It is also recommended to obtain a psychological evaluation with a full-scale IQ and adaptive testing to assist in determining the most appropriate services to meet your needs." 6. Resident 2's PASRR level II paperwork was requested by the survey team on 7/15/26 at 10:11 a.m. 7. Interview on 7/16/26 at 1:56 p.m. with LSW U revealed that she did not submit the PASRR level II until it was requested by the survey team on 7/15/26. She was not sure why it was not submitted before this date but said it should have been completed before the approved days expired. 8. Review of the provider's 7/15/25 Preadmission Screening and Resident Review (PASRR) policy revealed "It is the policy to screen all potential admissions on an individual basis. As part of the preadmission process, Sanford Care Center and Swing Bed will participate in the Preadmission Screening and Resident Review (PASRR) screening process (prescreening and Level I) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, Sanford Care Center and Swing Bed will not admit an individual with a mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and Sanford Care Center and Swing Bed's ability to provide the specialized services determined in the Level II screen process, the facility will coordinate with the South Dakota State ASA Nurse Consultant related to the individual needs of the resident as indicated. Annually and with any significant change of status, Sanford Care Center and Swing Bed will complete the PASRR Level I screen for those individuals identified per the Level II screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly."	F0645		

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F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for two of six sampled residents (2, and 30). Findings include: 1. Observation on 7/14/26 from 9:52 a.m. to 2:32 p.m., resident 2 was asleep in bed. 2. Observation on 7/14/26 at 2:14 p.m. resident 30 was in his wheelchair outside smoking a cigarette on the sidewalk, near the street, alone. 3. Review of resident 30's electronic medical record (EMR) revealed he was admitted on 2/19/26. His 5/15/26 Brief Interview for Mental Status (BIMS)	F0657	1. Resident 2's careplan was updated by the MDS coordinator to reflect current diet order, dining preferences, weight-loss interventions, and individualized approaches. Resident 30's careplan was updated by MDS with a smoking focus that included date of last assessment and that resident is independent with smoking. 2.All resident have the potential to be affected by the careplan inaccuracies. careplans will be reviewed by the interdisiplinary team during care conferences, mds reviews, and updated as needed. Careplans of residents that currently smoke and have weight loss were reviewed to ensure careplans reflected individualized care. 3.Education was provided by the administrator tothe MDS nurse that careplans need to reflect individualized plans for each resident on7/31/26 4.Audits of careplans will be done weekly x 4wk during care conferences by the interdisciplinary team, and then monthly x 3 months. any negative findings will be reviewed by the QAPI committee.	8/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD , CHAMBERLAIN, South Dakota, 57325

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F0657 SS = D	Continued from page 29 assessment score was 10 indicating he had moderately impaired cognition. He had diagnoses of cerebral palsy (a neurological disorder that permanently affects a person's ability to move, maintain balance, and sustain posture), chronic pain, and anxiety disorder. He had a smoking assessment completed on 4/13/26, which indicated he was able to wheel himself out to the designated smoking area. He could safely light his own cigarette and smoke the entirety of the cigarette without causing injury to himself. He was able to put out the cigarette and dispose of the cigarette butt in the designated trash can. His care plan did not indicate he was a smoker, or that a smoking assessment had been completed, or that he was safe to smoke independently. 4. Interview on 7/14/26 at 2:32 p.m. with certified nursing assistant (CNA) I regarding resident 2 revealed that she refused breakfast and lunch. She slept in during the day and will wake up in the evening. 5. Observation on 7/14/26 at 4:24 p.m., resident 2 was waking up but still lying in bed in the dark. 6. Review of resident 2's EMR revealed she admitted to the facility on 8/11/21. Her 6/19/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbances (a noticeable decline in cognitive abilities such as memory, attention, or problem-solving), psychotic disorder (a serious mental health condition characterized by a significant loss of contact with reality), unspecified disorder of adult personality and behavior (a mental health condition marked by enduring, inflexible patterns of thinking, feeling, and behaving that significantly deviate from cultural norms, cause distress or impair daily functioning), unspecified intellectual disabilities (significant limitations in intellectual functioning), depression, non-infective gastroenteritis and colitis (inflammation of the stomach, intestines, or colon that is not caused by an infection), and gastric ulcer without hemorrhage or perforation (an open sore on the stomach lining). Her 4/16/24 physician diet orders were for dysphagia (difficulty or discomfort in swallowing) diet, soft with thin liquids. There was a general nursing order on 3/10/26 to give 1 cup of coffee with morning medications in the room before getting the resident up for the day. Notify dietary aide to get breakfast ready after medications were given to	F0657		

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F0657 SS = D	Continued from page 30 anticipate her needs. There were no further supplemental dietary orders input into the physician order report. Her 6/26/26 care conference documentation indicated that licensed social worker (LSW) U, long-term care (LTC) activities G, minimum data set (MDS) coordinator V, and resident 2's power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) were in attendance. They reviewed her diet and her weight loss and discussed options to see about getting the resident to gain weight, as she refused her supplements and was becoming "more picky with what she eats." Resident 2's POA said she could bring resident 2 some snacks and have nursing regulate it more so resident 2 does not eat them all in one sitting. MDS coordinator V "will talk with the dietician about a 'peanut butter cup' therapy to see if that might help some. The staff will continue to monitor her diet/weights." Her 6/26/26 care plan indicated that resident 2 needed increased encouragement from the staff to get up and come out for meals. She was weighed weekly during her bath, and any increase or decrease of 4 lbs. would be reported to the charge nurse. Re-weights would be performed according to policy. Staff was to notify the provider of significant weight changes. Diet as ordered was a regular diet, International Dysphagia Diet Standardization Initiative (IDDSI) 6 soft and bite-sized, with tray set up as needed (prn). She was to be offered small to routine size portions at mealtimes. Staff were to ask her if she wanted second helpings. The second helpings offered were to be small portions. Fluid consistency was thin, but with a 2000 milliliter (mL) per day fluid restriction. Resident 2's care plan did not include information about offering supplements such as magic cup or "peanut butter cup" therapy, as indicated by care conference and dietary notes. It did not include interventions on how staff should encourage her to take part in mealtimes. Her care plan did not indicate a dysphagia diet as per the physician's order. Her 6/30/26 nutritional risk progress notes indicated that the resident has been refusing her chocolate coffee (chocolate Ensure in coffee); she was offered Magic Cups ice cream supplement at the noon meal. Staff reports that resident 2's acceptance of this supplement is variable and inconsistent. 7. Observation on 7/15/26 at 12:15 p.m. registered nurse (RN) J revealed that she woke resident 2 up	F0657		

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F0657 SS = D	Continued from page 31 for her medications and asked her if she wanted lunch. Resident 2 refused lunch. No additional supplements were offered at that time. There was no encouragement to attend lunch. 8. Observation on 7/15/26 at 12:42 p.m. of resident 30 was in his wheelchair outside smoking a cigarette on the sidewalk, near the street, alone. 9. Interview on 7/16/26 at 9:23 a.m. with minimum data set (MDS) coordinator V revealed care plans should be updated with changes as they occur, significant changes or MDS quarterly assessments. When asked if smoking would be on a resident care plan, she stated "It depends on the resident, if we feel like they are safe to independently she would not put it on the care plan." Staff are updated on who can smoke by the smoking list. She would add it to the care plan if a resident needed certain safety precautions. 10. Interview on 7/16/26 at 10:01 a.m. with director of nursing (DON) B revealed she expects smoking to be on a resident care plan. Along with the smoking assessment information and any precautions needed for the resident would be on the resident's care plan. 11. Interview on 7/16/26 at 1:21 p.m. with DON B revealed that she would expect the care plan to include interventions for the staff to try to encourage resident 2 to get up to attend meals. She would also expect the care plan to include the supplements the staff should be giving her. She said the supplements were also on the medication administration record (MAR) or treatment administration record (TAR) so the nurses knew to give them to the residents. 12. Review of the provider's 12/1/25 Care Plan policy revealed: Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders.	F0657		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F0695		

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F0695 SS = D	Continued from page 32 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that two of two sampled residents (21 and 37) on oxygen had their tubing changed weekly. Findings include: 1. Observation on 7/14/26 at 9:20 a.m. revealed resident 21's oxygen tubing was dated 6/29/26. Observation on 7/15/26 his oxygen tubing was dated 7/20/26. 2. Observation on 7/14/26 at 9:34 a.m. revealed resident 37's oxygen tubing was dated 6/29/26. Observation on 7/15/26 his oxygen tubing was dated 7/20/26 for the following Monday. 3. Observation and interview on 7/16/26 at 1:10 p.m. with Registered Nurse (RN) J regarding the dates on the resident's oxygen tubing revealed that resident 21 and 37's oxygen tubing were dated 7/20/26, which was the date it would expire and need to be changed. She stated the oxygen tubing should be changed weekly and dated at that time, not the date it expired. 4. Review of the electronic medical records for resident 37 indicated that the oxygen tubing had been changed weekly, but the dates on the tubing did not coincide with those records. Resident 21 did not have a physician's medical order to administer oxygen. 5. Interview on 7/16/26 at 2:36 p.m. with director of nursing (DON) B regarding resident weekly oxygen tubing change and dating revealed she expected the tubing to be changed weekly and dated at that time.	F0695	1For resident 21 and 37, new tubing was placed with accurate dates on the labels 7/17/26. labels with the start date and the discard date was implemented. 2. All other residents that use oxygen was reviewed by the DNS and provided the labels on the tubing with the start date and discard date. 3.Education was provided by the DNS to change oxygen tubing weekly on Monday's and to use the the labels with the start date and discard dates on 8/3/26 4. DNS or designee will conduct weekly audits for 4 weeks and monthly for 3 months. any negative findings will be reviewed by the QAPI committee.	8/18/26

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F0695 SS = D	Continued from page 33 6. Review of the provider's 7/30/25 oxygen administration policy revealed that oxygen administration is carried out only with a medical provider order. The disposable equipment should be changed weekly or according to the manufacturer's instructions and marked with date and initials.	F0695		
F0710 SS = D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to notify the physician of one of two sampled residents (2) who had unplanned significant weight loss (a loss of 5% (percent) of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days). Findings include: 1. Observation on 7/14/26 from 9:52 a.m. to 2:32 p.m., resident 2 was asleep in bed. 2. Interview on 7/14/26 at 2:32 p.m. with certified nursing assistant (CNA) I revealed that she refused breakfast and lunch that day. Resident 2 typically slept in during the day and will wake up in the evening. She slept in during the day and will wake up in the evening.	F0710	1.For resident 2: physician was notified on 8/5/26by the MDS nurse regarding resident's weightloss, recommendations were received and documented. 2. Other resident's that have significant weight loss were reviewed by the MDS Nurse to ensure that the doctor was notified, no other further issues identified. 3.The interdisciplinary team and dietitian will review significant weight loss of residents weekly during the interdisciplinary meeting. The DNS or designee will ensure the doctor is notfied of any significant weight loss. 4.The dietician or designee will complete weekly audits for 4 weeks and monthly for 3mo to ensure physician notification was completed. any negative findings will be reviewed by the QAPI committee.	8/18/26

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F0710 SS = D	Continued from page 34 3. Observation on 7/14/26 at 4:24 p.m., resident 2 was waking up but still lying in bed in the dark. 4. Review of resident 2's EMR revealed she admitted to the facility on 8/11/21. Her 6/19/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbances (a noticeable decline in cognitive abilities such as memory, attention, or problem-solving), psychotic disorder (a serious mental health condition characterized by a significant loss of contact with reality), unspecified disorder of adult personality and behavior (a mental health condition marked by enduring, inflexible patterns of thinking, feeling, and behaving that significantly deviate from cultural norms, cause distress or impair daily functioning), unspecified intellectual disabilities (significant limitations in intellectual functioning), depression, non-infective gastroenteritis and colitis (inflammation of the stomach, intestines, or colon that is not caused by an infection), and gastric ulcer without hemorrhage or perforation (an open sore on the stomach lining). Her weight on 7/12/26 was 121 lbs. Her weight on 4/12/26 was 134.5 lbs. This was a 10.04% weight loss in 90 days. Her weight on 7/12/26 was 121 lbs., and on 1/12/26 was 138.5 pounds (lbs.). This is a 12.64% weight loss in 180 days. Her documented weight on 5/17/26 was 127 lbs. This was a weight loss of 4 lbs. since the documented weight of 131 lbs. on 5/13/26. Her weight on 5/10/26 was 124.5 lbs., and her weight on 4/27/26 was 137 lbs., showing a weight loss of 12.5 lbs. Her weight on 2/11/26 was 130 lbs., on 2/10/26 135.5 lbs., and on 2/9/26 131.5 lbs., indicating weight variances of 4 or more lbs. Her 4/16/24 physician diet orders are for dysphagia (difficulty or discomfort in swallowing) diet, soft foods and with thin liquids. Her 6/26/26 care conference documentation indicated that licensed social worker (LSW) U, long-term care (LTC) activities G, minimum data set (MDS) coordinator V, and resident 2's power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) were in attendance. They reviewed her diet and her weight loss and discussed options to see about getting the resident to gain weight, as she refused her supplements and was becoming "more picky with	F0710		

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F0710 SS = D	Continued from page 35 what she eats." Resident 2's POA said she could bring resident 2 some snacks and have nursing regulate it more so resident 2 does not eat them all in one sitting. MDS coordinator V "will talk with the dietician about a 'peanut butter cup' therapy to see if that might help some. " The staff will continue to monitor her diet/weights." Her 6/30/26 nutritional risk progress notes indicated that the resident has been refusing her chocolate coffee (chocolate Ensure in coffee); she is being offered Magic Cups ice cream supplement at the noon meal. Staff reports that the resident's acceptance of this supplement is variable and inconsistent. 5. Observation on 7/15/26 at 12:15 p.m. registered nurse (RN) J revealed that she woke resident 2 up for her medications and asked her if she wanted lunch. Resident 2 refused lunch. 6. On 7/15/26 at 2:45 p.m., a request was made for documentation to resident 2's physician about weight variances. No documentation was received. 7. Interview on 7/16/26 at 1:21 p.m. with director of nursing (DON) B revealed that residents' weights were checked weekly, and if they have a 4 lb. difference, then the nursing staff would notify a physician. If the weight is a significant loss, then the provider is notified by being seen directly in the clinic or, if more urgent, in the emergency room (ER). 8. Review of the provider's reviewed 9/30/25 Weight and Height policy revealed "purpose to ensure that the resident maintains acceptable parameters of nutritional status regarding weight. To report changes in a resident's clinical condition (significant weight change) to physician and family and/or resident. To accurately measure weight and height. To monitor weight loss or gain in a resident. Weight procedure: the licensed nurse should notify the director of food and nutrition (DFN) within 24 hours regarding any significant weight change. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days, and 10 percent in 180 days."	F0710		
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F0760		

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F0760 SS = D	Continued from page 36 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure residents were free from significant medication errors for one of one sampled resident (36), who was not administered his physician-ordered dose of insulin by registered nurse (RN) J, which increased his risk for having diabetic complications, including hyperglycemia (an abnormally high blood sugar level). Additionally, resident 38 did not receive his calcium/vitamin D3/vitamin K medication from certified medication assistant (CMA) H because the label on the medication did not match the medication. Findings Include: 1. Observation on 7/15/26 at 12:03 p.m. of registered nurse (RN) J administering Novolog FlexPen (insulin aspart, a rapid-acting insulin in a prefilled pen. A needle attaches to the pen for medication administration) to resident 36. The ordered dose was 5 units (u). RN J injected the insulin into the resident's abdomen by pressing the medication dial at the end of the FlexPen. One second was counted from the start of the administration (when the pen is placed against the resident's stomach and the metered dose dial is pressed down) to the time the insulin pen was removed. She removed the pen from the resident's abdomen prior to the medication being fully dispensed into the resident's abdomen, as evidenced by when she pulled the insulin pen away from the resident; the insulin then expelled out of the needle onto the resident's skin. 2. Review of resident 36's electronic medical record (EMR) indicated she admitted to the facility on 9/3/25. Her 5/29/26 BIMS assessment score was 10, which indicated her cognition was moderately impaired. Her MAR indicated a 4/15/24 physician's order for Novolog FlexPen U-100 Insulin (insulin aspart U-100) 100unit/3mL, give 5 units subcutaneously with meals at 8:30 a.m., 12:00 p.m., and 5:30 p.m. Her diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar that causes damage to multiple peripheral nerves, usually leading to pain, numbness, or tingling in the hands and feet), chronic kidney disease stage 3 (moderate kidney damage indicating reduced kidney function), hypo-osmolality (low concentration of particles in	F0760	1 For resident 36, education was provided to the charge nurse J by the DNS on 7/16/26. For resident 38 not receiving the medication due to incorrect labeling, education was provided by the DNS on 7/17/26 to CMA H to notify the charge nurse of the incorrect labeling so the pharmacy could be notified for clarification. 2. all resident"s medication cards were cross checked with the EMAR by the DNS and MDS nurse to ensure no other discrepencies were found, no further issues were identified. 3. The DNS will provide education to all nurses and cma's of the medcation administration policy and do competency validation on August 18th. 4. Insulin administration auditswill be completed weekly x 4 weeks and monthly x 2months by DNS or designee. Medication administration audits will be completed by the DNS or designee on 2 residents weekly for 4 weeks and monthly for 2 months. Any negative findings will be brought the Qapi committee for further review.	8/18/26

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F0760 SS = D	Continued from page 37 the blood, usually from having too much water compared to electrolytes), and hyponatremia (sodium levels are low in the blood), chronic systolic (congestive) heart failure (a long-term condition where the heart's left ventricle weakens and can't pump blood effectively, leading to fluid buildup in the body), rheumatic mitral stenosis (a narrowing of the mitral valve caused by rheumatic fever, which restricts blood flow from the left atrium to the left ventricle and can lead to breathing difficulty and fatigue), nonrheumatic mitral insufficiency (also called mitral regurgitation, is when the mitral valve doesn't close properly allowing blood to leak backward from the left ventricle into the left atrium), and pulmonary hypertension (high blood pressure in the arteries that carry blood from the right side of the heart into the lungs, usually caused by narrowed or blocked lung vessels). 3. Interview on 7/15/26 at 4:28 p.m. with RN J revealed her process for insulin administration was that she would wait three seconds before removing the insulin pen from the resident to ensure the resident receives the full dose. She agreed that if the insulin was expelled onto the resident's skin when removing the needle from the injection site, the resident did not get her full ordered dose. RN J stated that if the resident did not get her full dose, she would tell the director of nursing (DON), monitor the patient, and notify the provider. 4. Observation on 7/16/26 at 7:42 a.m. of CMA H during medication pass for resident 38 revealed two medication blister packs (a card with medications sealed in individual plastic bubbles) for the morning dose for LDR Vit C600+D3/MINS CHEW 60 EACH. Generic for LDR VIT C600+D3/MINS CHEW CENTURY, each containing one-half tab. CMA H prepared to give the morning dose by removing each half tab from the medication blister packs into a separate paper cup. 5. Interview and EMR review on 7/16/26 at 7:50 a.m. with CMA H revealed a physician's order for Calcium 500 milligram (mg)-Vitamin D3 1000 u – Vitamin K 40 micrograms (mcg) chewable tablet 1 tab twice a day. CMA H acknowledged that the medication blister pack label and the physicians' orders in the EMR did not match. CMA H stated that she did not know the process for reporting that type of error, but "I can tell the nurse or the DON. When we complete the medication card changeover to the new packs, the staff are supposed to double-check they match the MAR and previous cards." 6. Interview on 7/16/26 at 7:56 a.m. with DON B	F0760		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD , CHAMBERLAIN, South Dakota, 57325

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F0760 SS = D	Continued from page 38 revealed that she expected the medication cards would match the physicians' order on the MAR. 7. Review of resident 38's EMR indicated she admitted to the facility on 10/22/25. Her 4/17/26 BIMS assessment score was 12, which indicated her cognition was moderately impaired. Her diagnoses included weakness, age-related osteoporosis (a condition where bones become thin, weak, and more likely to break easily) without current pathological fracture, and chronic kidney disease stage 3 moderate kidney damage (indicating reduced kidney function). 8. Interview on 7/16/26 at 1:21 p.m. with the DON B revealed that a resident not receiving their full ordered dose of insulin, the resident's physician not being notified, and the lack of increased monitoring for resident 36 after the medication error were considered a significant medication error. 9. Interview on 7/16/26 at 3:15 p.m. with DON B revealed that the label on the medication blister pack was incorrect for resident 38's calcium/vitamin D/vitamin K order. She expected the medication to have the correct label on it. 10. Observation on 7/16/26 at 3:25 p.m. the medication blister packs for resident 38's calcium/vitamin D/vitamin K order were still in the medication cart. 11. Review of the provider's reviewed 3/2/26 Medication Errors policy revealed "the location will have medication error rates of five percent or less and those residents are free of significant medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident, and or responsible party and documented in the SAFE Event Reporting application. Definitions from the State Operations Manual Significant Medication Error one which causes the resident discomfort or jeopardizes his or her health and safety. Wrong Dose/Amount when the resident receives an amount of medication that is greater than or less than amount ordered by the prescriber." 12. Review of the provider's reviewed 3/30/26 Medication: Administration Including Scheduling and Medication Aides revealed "The resident has the right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Procedure: Follow the "Six Rights":	F0760		

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F0760 SS = D	Continued from page 39 right medication, right dose, right resident, right route, and right documentation. Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication."	F0760		
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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: Based on observation, interview, document review, and policy review, the provider failed to ensure appropriate hand hygiene was performed by one of one observed cook (Q) to meet professional food cleanliness standards. Findings include: 1. Observation of the noon meal on 7/14/26 at 12:13 p.m. revealed cook Q plating meals for the residents in the Hamilton Hall dining room. She stood between a serving table that held the residents' meal tickets and trays and a counter that held steam pans containing polish sausage, sauerkraut, and peas. A bag of hot dog buns sat on the counter near the	F0812	1. No residents identified as impacted. Education will be provided to Cook Q and all dietary staff regarding hand hygiene, glove use, and meal service procedures on 8/20/26 by the infection preventionist or designee. 2. All residents have the potential to be impacted by failure to follow appropriate hand hygiene from dietary staff. All dietary staff have the potential to be affected by the deficient practice. 3.A dietary staff meeing will be held on 8/20/26, including education and competency validation on hand hygiene and glove use. Annual competency validation will be done on all dietary staff for hand hygiene and glove use for safe meal services. 4. Infection prevention nurse or designee will conduct meal service observations for evidence of proper hand hygiene twice weekly for 4weeks and monthly x 2 months. any negative findings will be reviewed by the QAPI committee.	8/20/26

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F0812 SS = D	Continued from page 40 steam pans. A sink, a box of gloves, and a trash can were next to the counter. Beside the serving table stood a rack of dessert bowls containing pears and potato salad. Cook Q was wearing gloves and a hairnet. At 12:22 p.m., cook Q used her left gloved hand to pick up a plate and her right gloved hand to take a hot dog bun from the bag and place it on the plate. She picked up a serving tong with her right hand and placed sausage on the bun, then used a different serving scoop to place sauerkraut on the plate, and a third scoop to place peas on the plate. Each utensil was returned to its steam pan after use. She then used her right hand to retrieve bowls of potato salad and pears from the rack, placing them on the plate she held in her left hand. At 12:24 p.m., wearing those same gloves, she set the plate on the serving table, left the serving line, walked across the dining room to the kitchenette area, opened the refrigerator door, retrieved a bottle of ketchup and a bottle of mustard, set them on the adjacent counter, and closed the refrigerator door. Carrying the ketchup in one hand and the mustard in the other, she walked back to the serving line, set the mustard bottle on the serving table, opened the ketchup bottle and used both hands to squeeze ketchup onto the sausage on the plate she had prepared. She set the ketchup bottle on the serving table, picked up the mustard bottle, opened it, used both hands to squeeze mustard onto the sausage, and set the mustard bottle on the serving table. She picked up the plate and gave it to certified nursing assistant (CNA) L, who took the plate to one of the residents. Cook Q removed her gloves, put them in a trash can near the sink, and put on a new pair of gloves without washing her hands. At 12:25 p.m., cook Q began to repeat the plating process. She held a plate with her left gloved hand and used her right gloved hand to retrieve a hot dog bun out of its bag, then access serving tongs and scoops to plate the sausage, sauerkraut, and peas. She retrieved bowls of potato salad and pears from the rack, placed them on the plate, and asked CNA L to put ketchup and mustard on the sausage, saying, "I can't because I have gloves on." CNA L did so and took the plate to one of the residents. Cook Q picked up another plate, retrieved a hot dog bun out of its bag, and repeated the plating process. After handing the third plate to CNA L, cook Q picked up a pen with her right hand and wrote on a piece of	F0812		

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F0812 SS = D	Continued from page 41 paper by the residents' meal tickets while resting her left hand on the serving table. She set the pen down and turned back to the serving counter, picked up a plate, and used the tongs to retrieve a sausage. She used the serving tongs to hold the sausage in place while cutting it up with a pizza cutter, then plated the sauerkraut and peas before handing the plate to CNA M, who delivered it to one of the residents in the dining room. Between 12:30 p.m. and 12:33 p.m., cook Q prepared three more plates, retrieving the hot dog buns with her right gloved hand. Each time she handed a plate to CNAs L and M, cook Q rested her left hand on the serving table while using her right hand to write on a resident meal ticket. At 12:34 p.m., with those same gloved hands, cook Q reached above the serving counter, opened a cupboard door, retrieved a napkin, and closed the cupboard door. She placed the napkin on a meal tray which contained a plate of food, picked up the tray with both hands, and handed the tray to CNA L. She continued preparing plates without changing gloves or performing hand hygiene. At 12:38 p.m., wearing those same gloves, cook Q picked up a glass covered with saran wrap, removed the saran wrap, picked up the glass with her fingers surrounding the rim of the glass, and set the glass on a meal tray. She resumed the plating process, and after handing the plate to CNA L, she rested her left hand on the serving table and wrote on meal tickets with her right hand. At 12:40 p.m., with the same gloved hands, cook Q reached above the serving counter, opened a cupboard door, retrieved a meal tray, closed the cupboard door, and set the tray on the serving table. She placed silverware on the tray and prepared a plate with sausage, sauerkraut, and peas, then placed a plate cover on the plate and handed the tray to CNA L, who delivered the tray to a resident room. Cook Q then write on a meal ticket and resumed the plating process. At 12:43 p.m., cook Q pulled the serving tong and scoops out of the steam pans and placed them all on a single plate to take to the sink. She asked the residents in the dining room if they wanted anything else, and one resident asked for another sausage.	F0812		

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F0812 SS = D	Continued from page 42 Cook Q retrieved a hot dog bun from its bag with her right hand, put it on a plate, used the serving tong from the plate of dirty utensils to place sausage on the bun, put the tong back onto the plate of dirty utensils, and walked the plate over to a resident. She returned to the serving counter and loaded all the dishes onto a cart, which she took through the dining area to the kitchenette sink. She removed her gloves at 12:48 p.m. as CNA M told her a resident wanted another sausage. Cook Q walked over to the cart where she had placed the steam pans, put a glove on her right hand, picked up a plate and used her right gloved hand to retrieve a sausage from the steam pan. She told CNA M, "The tongs are all dirty. This is acceptable, isn't it? That's what we do in the kitchen," and laughed. At 12:50 p.m. she left the kitchenette to take the cart of dirty dishes back to the main kitchen. 2. Interview on 7/15/26 at 11:05 a.m. with dietary manager T revealed that she expected her staff to change gloves and perform hand hygiene between each task. "She should not pick up a bun with gloved hands if she is also using those hands to pick up serving utensils and open refrigerator or cupboard doors." 3. Observation on 7/16/26 at 7:44 a.m. in the kitchenette revealed cook Q frying eggs for residents eating breakfast in the Hamilton Hall dining room. Cook Q was wearing gloves and a hairnet. She walked away from the stove, opened the refrigerator door, retrieved a bowl of eggs, closed the refrigerator door, and set the bowl of eggs on the counter next to the stove. She walked through the dining room to the serving counter, opened a cupboard and retrieved a bowl, closed the cupboard, and took the bowl back to the stove area. She cracked two eggs into the pan on the stove, removed her gloves, put them in a trash can, and put on a new pair of gloves without performing hand hygiene. Cook Q then dispensed water from the coffee machine into two bowls and put them in the microwave to heat up the water. After setting the microwave timer, she placed her left gloved hand on the counter and her right gloved hand on the edge of the stovetop. When the microwave timer sounded, cook Q removed the bowls and placed them on a serving tray, made toast by handling the bread with	F0812		8//26

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F0812 SS = D	Continued from page 43 her gloved hands, and took a tray of juice glasses out of the refrigerator. She put everything on the serving cart and rolled it through the dining room to the serving table. She opened cupboard drawers to retrieve silverware and individual containers of jelly. She used a spoon to stir oatmeal into the two bowls of hot water, put everything on individual meal trays and served the trays to the residents sitting at the dining room table. She retrieved silverware and another bowl from the cupboard, picked up a container of milk from the serving table, poured milk into the bowl, added oatmeal, stirred it, and served the bowl to a resident at the dining table. Wearing those same gloves, cook Q repeated the process for another bowl of oatmeal, dispensing water from the coffee machine and heating it in the microwave, resting her gloved hands on the counter and stove handle while she waited for the microwave to sound. She retrieved a new gallon of milk from the refrigerator, poured milk into a glass, put the milk back in the refrigerator, and carried the bowl of hot water and the glass of milk with her fingers surrounding the rim. She placed both items on a tray on top of a serving cart, took a spoon from a drawer and stirred oatmeal into the bowl, then wheeled the cart over to a resident at the dining table. She took the glass of milk off the tray with her fingers around the rim of the glass and set it on the resident's table. Cook Q continued moving between the dining room and the kitchenette, opening cupboards to retrieve dishes, napkins, and silverware, which she added to a tray on the serving cart. At 7:57 a.m. she left the kitchenette and wheeled the cart and a meal tray to a resident's room. She knocked on the door, announced herself, took the tray into the room, then wheeled the cart back to the kitchenette area. She removed her gloves, put them in the trash, washed her hands, retrieved a can of pop from the refrigerator and took it to one of the residents in the dining room. She proceeded to serve coffee to the residents and take dirty dishes to the kitchenette sink without wearing gloves or washing her hands. 4. Observation on 7/16/26 at 8:15 a.m. in the Hamilton Hall dining room revealed cook Q at the serving counter, opening a cupboard to restock individual containers of cream cheese and jelly. She	F0812		

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F0812 SS = D	Continued from page 44 was wearing gloves. At 8:17 a.m. she closed the cupboard door, removed her gloves, and put them in the trash. She did not perform hand hygiene. 5. Interview on 7/16/26 at 8:20 a.m. with cook Q revealed that she usually works in the main kitchen and was filling in for a dietary aide who was on vacation. "I haven't worked in this dining room for a while." She said she wears gloves "most of the time" because she has a cyst on her finger that recently ruptured. She said that when wearing gloves, "I make sure I don't touch the food. As long as I don't touch the food, then I don't have to change my gloves." 6. Review of the provider's personnel file training documentation revealed that cook Q completed hand hygiene training and glove use education on 4/5/21, and repeated hand hygiene training on 8/25/25. She also successfully passed a hand hygiene and food temperature competency assessment on 5/26/26. 7. Review of the provider's 7/14/26 Hand Washing and Glove Use-Food Nutrition Services policy revealed that staff were to use uncontaminated, disposable gloves for single tasks, and to wash hands when switching tasks and after performing any activity that could contaminate hands. The policy read, "Employees involved in food preparation, distribution and serving must consistently utilize good hygienic practices and techniques," and that employees do not need to wear gloves when distributing food to residents at the dining table unless they have a cut or sore, which should then be double covered with a bandage and a glove. The policy revealed that employees should use proper utensils and single-use gloves for food handling to reduce the risk of cross-contamination. Hand washing should occur after touching any contaminated object including dirty utensils and dirty dishes, before and after using gloves, and between dirty and clean dish handling. Gloves should be changed before handling ready-to-eat foods, any time contamination is suspected, when touching a doorknob or faucet, and when coming in contact with something that may have been contaminated such as pots, pans, trays, and utensils. 8. Review of the provider's 12/26/24 Care Center Safe Meal Service, LTC policy revealed that when plating and delivering resident meals, food service	F0812		

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F0812 SS = D	Continued from page 45 staff should "pay attention to potential contamination during delivery and complete proper hand washing or glove change if needed."	F0812		
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure that 1 of 1 sampled resident 17 had his call light in reach on 7/14/26, 7/15/26, and 7/16/26 after he returned from therapeutic leave. Findings include: 1. Observation on 7/14/26 at 9:00 a.m. revealed resident 17 in his room in his bed. There was no call light within reach. There was no call light plugged into the wall outlet. Resident 17 stated he was there to recuperate from drinking and from fractures to both of his hips. He stated he could get up and walk around. He stated he did not need a call light. 2. Observations on 7/15/26 at 9:15 a.m. and 7/16/26 at 12:49 p.m. revealed resident 17 was not in his room and there was no call light plugged into the wall outlet near his bed. 3. Observation and interview on 7/16/26 at 12:50 p.m. with certified medication assistant (CMA) H revealed that resident 17's room did not have a call light plugged into the wall near his bed. She stated he had been on therapeutic leave from 7/10/26 to 7/13/26, and his room had been updated with new flooring. She stated his room had been cleared out, but items were brought back into the room, and his call light near the bed was not plugged back into the wall. She stated resident 17 had returned from his	F0919	A call light was installed and made accessible in Resident 17's room on 7/16/26. 2. An audit was conducted by the DNS on 8/1/26 of all resident's rooms to esnure call lights were functioning and within reach, no further issues were identified. 3. Staff education will be done by the Administrator or designee on 8/18/26 on call lights being present in all resident rooms and within reach of the resident. 4. The DNS or designee will complete monthly room audits for 4 months to verify call lights are present and accessible. Any negative findings will be reviewed by the QAPI committee.	8/18/26

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F0919 SS = D	Continued from page 46 leave on 7/13/26 and acknowledged he must not have had a call light since he returned to the facility that day. 4. Interview on 7/16/26 at 1:15 p.m. with registered nurse (RN) J revealed she was not aware that resident 17 had not had his call light in reach since returning from his leave on 7/13/26. She acknowledged that residents should have a call light in reach for assistance at all times. 5. Review of the provider's 7/8/25 call light policy revealed that residents always had a method of calling for assistance.	F0919		

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	10606	A. BUILDING _____ B. WING _____	07/16/2026

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/14/26 through 7/16/26. Sanford Chamberlain Care Center was found not in compliance. S301	S 000	The plan of correction is prepared and/or executed sooely because it is required by the provisions of federal and state law.	
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all personnel providing dietary and food-handling services. Training must be completed within thirty days of hire and annually for all dietary or food-handling personnel. The training must include the following subjects: (1) Food safety; (2) Handwashing; (3) Food handling and preparation techniques; (4) Food-borne illnesses; (5) Serving and distribution procedures; (6) Leftover food handling policies; (7) Time and temperature controls for food preparation and service; (8) Nutrition and hydration; and (9) Sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on record review and interview, the provider failed to ensure one of two dietary employees reviewed had completed the required dietary trainings (food safety, handwashing, food handling and preparation techniques, foodborne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements) within 30 days of hire for food	S 301		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jody Becker — TITLE: Administrator — (X6) DATE: 8/8/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10606	A. BUILDING: _____ B. WING _____	07/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD CHAMBERLAIN, SD 57325

(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 301	Continued From page 1 service assistant (FSA) R. Findings include: 1. Review of the provider's employee personnel records revealed that FSA R was hired on 2/2/26. As of 7/16/26, she had not received training on food safety, handwashing, food handling and preparation techniques, foodborne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. 2. Interview on 7/16/26 at 12:53 p.m. with Director of Nursing (DON) B revealed that she expected employee training to be completed by its assigned due date, typically one month after it was assigned. If employees did not complete training by the assigned due date, she expected it to be completed before they could return to work. DON B agreed that FSA R had not completed the required training on food safety, handwashing, food handling and preparation techniques, foodborne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements within 30 days of hire.	S 301	1.FSA R completed the required training by 7/17/26. 2.A review of all required training for dietary staff was conducted by the administrative assistant, and 1 other staff member was identified in non-compliance and completed the training before the next scheduled shift. 3. dietary supervisor will ensure that the required training for dietary staff is deployed to the staff member's success centers and that the required training will be completed within 30days of employment. The required training has been added to the general orientation checklist. 4. The ancillary department supervisor will audit all current dietary staff and new dietary employees completion of required trainings monthly x 4 months. Any negative findings will be reviewed by the QAPI committee.	8/18/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD , CHAMBERLAIN, South Dakota, 57325

(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
E0000	Initial Comments 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 on 7/15/26. Sanford Chamberlain Care Center was found in compliance.	E0000		

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 reverse for further 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
Jody Becker	Administrator	8/8/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING 02 - BUILDING 2... B. WING	07/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN CARE CENTER	300 S BYRON BLVD , CHAMBERLAIN, South Dakota, 57325

(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
K0000 Bldg. 02	INITIAL COMMENTS A recertification survey was conducted on 7/15/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sanford Chamberlain Care Center was found in compliance.	K0000		

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 reverse for further 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
Jody Becker	Administrator	8/8/2026