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

PRINTED: 08/01/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		43A098	B. WING	=	07/27/2023		
	ROVIDER OR SUPPLIER CARE CENTER VERMI	LLION	125	STREET ADDRESS, CITY, STATE, ZIP CODE 125 S WALKER STREET VERMILLION, SD 57069			
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE COMPLETION		
F 000	INITIAL COMMENTS		F 000				
	with 42 CFR Part 483 for Long Term Care f	th survey for compliance 3, Subpart B, requirements acilities was conducted from /23. Sanford Care Center ance.					
n							
-							
-							
LABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	Administrator	(X6) DATE 8/2/2023		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a pan 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.

AUG 0 2 2023 Obsolete

FORM CMS-2567(02-99) Previous Versions

Event ID: AIFL11

Facility ID: 0114

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		43A098	B. WNG_	NG		07/27/2023	
NAME OF PROVIDER OR SUPPLIER SANFORD CARE CENTER VERMILLION				STREET ADDRESS, CITY, ST 125 S WALKER STREET VERMILLION, SD 57069			•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECT CROSS-REFEREI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
E 000			E	000			
-	CFR Part 482, Subpa Emergency Prepared Term Care facilities w	ey for compliance with 42 art B, Subsection 483.73, dness, requirements for Long was conducted from 7/25/23 aford Care Center was found					
							5.
-				-			
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	F	TITLE		(X6) DATE 8/2/2023	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction 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.

Dbsole@UG 0 2 2023

FORM CMS-2567(02-99) Previous Versions

Event ID: A FL11

Facility ID: 0114

If continuation sheet Page 1 of 1

South Dakota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 07/27/2023 10697 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 125 S WALKER STREET SANFORD CARE CENTER VERMILLION VERMILLION, SD 57069 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) S 000 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 7/25/23 through 7/27/23. Sanford Care Center Vermillion was found in compliance. S 000 Compliance/Noncompliance Statement S 000 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/25/23 through 7/27/23. Sanford Care Center was found

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Administrator

LQZ911

8/1/2023

STATE FORM

in compliance.

AUG 0 1 2023

SD DOH-OLC

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