

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 11029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/18/2026
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NAME OF PROVIDER OR SUPPLIER SANFORD HOSPICE CENTENNIAL COTTAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 6301 W 43RD STREET SIOUX FALLS, SD 57106
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>Compliance Statement</p> <p>A licensure survey for compliance with Administrative Rules of South Dakota 44:80, requirements for residential hospice facilities, was conducted from 3/17/26 through 3/18/26. Sanford Hospice Centennial Cottage was found in compliance.</p> <p>A complaint survey for compliance with Administrative Rules of South Dakota 44:80, requirements for residential hospice facilities, was conducted from 3/17/26 through 3/18/26. The areas surveyed were quality of care, patient assessment, and patient rights. Sanford Hospice Centennial Cottage was found in compliance.</p>	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Dylan Bunting</i>	TITLE Administrator	(X6) DATE 3/24/2026
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