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

PRINTED: 04/17/2025 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SANFORD MEDICAL CENTER  SUMMARY STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  PARTY MEETY TAG  SUMMARY STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  PREFIX TAG SUMMARY STREET PREFERED BY FILL REQULATORY OR US. IDENTIFYING INFORMATION)  A recertification health survey for compliance with 42 CFR Part 405, Subpart U, requirements for End Stage Renal Disease Services, was conducted from 4/15/25 through 4/16/25, Sanford Modical Center was found in compliance.  ADD TOWN STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TOWN STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  PREFIX TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET POST OF PICE BOX 5039 SIOUX FALLS, SD 57117  TAG STREET ADDRESS. CITY, STATE, ZIP CODE STREET, SD 57117  TAG STREET ADDRESS. CITY, STATE, ZIP CODE STREET, SD 57117  TAG STREET, SD	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
SANFORD MEDICAL CENTER  30 SUM FALLS, SD 57117  (X4) ID SUMMAY STATEMENT OF DEFICIENCIES SIGNATURE  10 PREFIX TAG STATE POST OFFICE BOX 5039 SIOUX FALLS, SD 57117  V 000 INITIAL COMMENTS  A recertification health survey for compliance with 42 CFR Part 405, Subpart U, requirements for End Stage Renal Disease Services, was conducted from 415/25 through 4/18/25, Sanford Medical Center was found in compliance.			432303	B. WING		04	04/16/2025		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  V 000  INITIAL COMMENTS  A recertification health survey for compliance with 42 CFR Part 405, Subpart U, requirements for End Stage Renal Disease Services, was conducted from 4/15/25 through 4/16/25. Sanford Medical Center was found in compliance.	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1305 WEST 18TH STREET POST OFFICE BOX 5039				
A recertification health survey for compliance with 42 CFR Part 405, Subpart U, requirements for End Stage Renal Disease Services, was conducted from 4/15/25 hrough 4/16/25. Sanford Medical Center was found in compliance.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI	X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
44705		A recertification healt with 42 CFR Part 405 for End Stage Renal conducted from 4/15/ Medical Center was f	th survey for compliance 5, Subpart U, requirements Disease Services, was (25 through 4/16/25. Sanford found in compliance.						
					4/17/25		(AB) DATE		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		432303	B. WING		04	04/16/2025	
NAME OF PROVIDER OR SUPPLIER  SANFORD MEDICAL CENTER			•	STREET ADDRESS, CITY, STATE, ZIP COD 1305 WEST 18TH STREET POST OFFIC SIOUX FALLS, SD 57117	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
E 000	CFR Part 494, Subpa 494.62, Emergency P for End Stage Renal I	Preparedness, requirements Disease Services, was 25 through 4/16/25. Sanford	E				
ABORATORY (	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Twyla Nordquist, RN, BSN, CNN

Dialysis Director

4/17/25

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.