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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/11/25 through 6/12/25. Areas surveyed included nursing services related to potential abuse/neglect, resident safety related to falls, and staff training. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F600, F657, and F689.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI) review, electronic medical record (EMR) review, video footage review, interview, and policy review, the provider failed to protect the resident's right to be free from physical abuse by: *One of one certified nursing assistant (CNA) (D) who responded to falling incidents with physical	F 600	1. Corrective action to residents affected: a. On 4/7/25, a complete physical assessment was completed for Resident #1 by DON, and MDS with any findings being addressed immediately. Resident care plan was reviewed on 6/29/25 to ensure accuracy of interventions were in place. We were unable to complete a trauma assessment on resident on 4/7/25 due to the resident being cognitively impaired, with a BIMS score of 0. Resident #1 is following up with Sanford Psychiatry appointments as ordered. b. Residents with a BIM score greater than 10 were interviewed on 4/7/25, with no concerns regarding abuse and neglect by staff being noted. Resident care plans with a focus on dementia with corresponding behaviors have been audited to ensure interventions are up to date and are effective with resident. 2. Identify other Potential Residents Affected: a. All residents can be impacted if the following measures are not taken: i. DON or designee will ensure staff are properly trained in Abuse and Neglect Reporting ii. DON or designee will ensure staff understand and are properly trained to intervene and speak up for safety on cases of suspected abuse iii. DON or designee will ensure that staff are educated to use the ARCC Tool to escalate concerns to management. Each staff member received and signed off on getting a handout/copy of the ARCC Tool. This will also be posted in the LTC Staff breakroom. 1. ARCC: a. A=ASK a question b. R=Make a REQUEST c. C=Voice a CONCERN by saying the safety phrase “I have a concern.” d. i. (if no success…) e. C=Use CHAIN of Command (Continued on Page 2)	7/11/2025

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erica Peterson | TITLE: Administrator | (X6) DATE: 7/2/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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F 600	Continued From page 1 force and restraint for one of one sampled resident (1) with cognitive impairment. *Eight additional staff members (E, G, H, I, J, K, L, and M), identified as present at the time the physical abuse occurred, who did not intervene or report those incidents to a supervisor at the time those incidents occurred. Findings include: 1. Review of the provider's 4/7/25 SD DOH FRI revealed: *On 4/7/25, the provider reviewed video footage of resident 1's falls from 4/6/25. *The video footage revealed CNA D "assisted [resident 1] roughly back into his wheelchair after he had fallen." *CNA D "pushed him [resident 1] up to the desk and locked the brakes on his wheelchair so he was not able to move around ..." *CNA D "did not get the nurse when he fell to do an assessment." *"[The] Nurse completed [an] assessment on 4/7/2025 and [resident 1] has some bruises on his arms." *Resident 1 "was showing signs of increased anxiety during his interactions with CNA [D]." *CNA D "did state that she did become frustrated ..." and "should have stepped away." *"[Licensed practical nurse (LPN) J] stated that she was in report [staff communication of residents' status] when these events took place, and no one reported these events until after report." *On 4/14/25, when interviewed by director of nursing (DON) B and licensed social worker (LSW) O, Certified medication assistant (CMA) I reported that CNA D had "transferred [resident 1] back into his wheelchair after his fall without the nurse assessing him first."	F 600	3. Measures put into place or Systemic Changes made to ensure this will not reoccur: a. Success Center learning modules were sent out 6/13/25 to LTC Staff, but will be dispersed to ALL staff and completed by 7/11/25. Leadership team initiated Angel Rounding on 06/13/25 and will continue to be performed weekly, along with daily rounding by MDS, DON or designee. b. Leadership team initiated Angel Rounding on 06/13/25 and will continue to be performed weekly, along with daily rounding by MDS, DON or designee. Angel Rounds will be completed indefinitely. i. Angel rounds are a tool used to monitor cleanliness of the facility, dignity of the resident, facility in good repair and to check resident condition(s) and if they have any complaints/grievances. c. Resident #1's whole care plan was reviewed to ensure that it is appropriate for the resident and if any updates need to be made. Care plan review completed on 6/29/25. DON or designee will ensure all direct care staff have the resources necessary to provide individualized resident care. We will continue to audit the Abuse and Neglect Policy education sign off sheet from previous survey to ensure completion. d. Education on abuse and neglect was started on 6/13/25 and will be completed by 7/11/25 with all LTC staff and auxiliary staff, which includes dietary, maintenance EVS, Physicians, management, and all nursing staff in hospital. This education will include the importance of speaking up and intervening if abuse is suspected, and how abuse and neglect can be reported to management. Education on Sanford SAFE Skills and how to use the (Continued on Page 3)	7/11/205

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F 600	Continued From page 2 *CMA I "noted that [CNA D] was laughing at [resident 1's] statements," but "did not recall any specific instances where [CNA D] was rough with [resident 1]." *"Education was immediately [on 4/7/25] provided to all nurses and CNAs regarding proper procedures after a fall, including notifying the nurse of the fall so they can complete an assessment ... All staff was [were] also educated on proper times to lock wheels on wheelchairs, and safely transferring residents." *"Resident cares with [resident 1] will also be audited randomly for the next 2 months and then prn [as needed] to ensure appropriate interactions from staff." *"New staff will be trained upon hire on managing residents with dementia." *CNA D was terminated "immediately after her interview on 4/7/25, no longer allowing her to provide resident care" at that facility. 2. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 7/25/23. *His 3/28/25 Minimum Data Set (MDS) assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *His diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (a mental state where a person loses touch with reality), mood disturbance (a serious mental illness that causes persistent and intense changes in a person's mood energy and behavior), general anxiety disorder, Alzheimer's Disease, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), and conduct disorder (a mental health condition	F 600	ARCC tool to escalate concerns utilizing the chain of command will be covered. Pop quizzes were implemented by DON on 6/13/25 with LTC staff and will continue to be completed with all direct care staff. These will be completed by 7/11/25. DON or designee will oversee this education and ensure that it is complete. Any employees that do not complete education by 7/11/25, will be educated before they are allowed to work their next shift (PRN or scheduled). e. A PowerPoint presentation will be provided to all staff by 7/11/25 on speaking up for safety, the ARCC Tool and mandatory reporting f. Step by step guides with screenshots have been placed at each nurses' station as a resource on how to successfully add new fall interventions and updates to the care plan. 4. Monitor Process for the system change including frequency and person responsible: a. DOO or designee will monitor 1 random,1 hour camera footage snips, especially for nights and weekends to ensure appropriate care that is free of abuse is provided to residents. Camera footage monitor form will be from random shifts. This will be monitored daily for 4 weeks, then 5 random snips per month for 4 months. Results will be reported by DON or designee to the monthly QAPI meeting for 4 months or until the committee deems necessary. b. MDS or designee will monitor care plan documentation to ensure care plan intervention updates are being made by nurses for each fall and that care plans are up to date weekly for 1 month, then monthly for 4 months. Results will be reported by DON or designee to the monthly QAPI Meeting for 4 months or until the committee deems necessary. (Continued on Page 4)	7/11/2025

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F 600	Continued From page 3 that involves a persistent pattern of aggressive and antisocial behavior). *His care plan indicated, "Inappropriate behaviors related to dementia. He demonstrates behaviors which include restlessness, wandering, combative, resists cares, verbally abusive, disruptive to other[s], [and] varying mood." -His care plan "Approaches" included: --"Resident will have 2 staff assist [assistance of two staff] with cares when given due to aggressive behaviors." --"If [Resident 1] becomes restless try these [non]pharmacological interventions like having the dog sit with him, wheel him around the facility in his wheelchair, visiting with him in a quiet setting or listening to calming music, resting on the couch in dining room with lights lowered and giving him snacks or something to drink." --"When approaching [resident 1] come from the front and not behind or on his sides as this can startle him." *Resident 1 was out of the facility and unavailable for interview throughout the survey. 3. Interview and review of the 4/6/25 video footage on 6/12/25 at 10:12 a.m. with director of finance N, DON B, and LSW O revealed: *Resident 1 fell on 4/6/25 at 12:45 p.m., 6:04 p.m., 6:12 p.m., and at 6:51 p.m. *At 12:45 p.m., resident 1 stood up from his Broda Pedal Wheelchair (a specialized high-back reclining wheelchair with upper body support that allows a person to self-propel with their hands or feet) that was positioned at the counter in front of the nurses' station. CNA D approached resident 1. Resident 1 swung his arm at her. CNA D stepped back, and resident 1 fell to the floor. -Without requesting assistance or notifying a nurse, CNA D reached around resident 1 and,	F 600	c. DON or designee will complete rounding 5x/week observing care on 5 residents for 1 month, then 2x/week observing care on 5 residents for 4 months to observe that resident care is provided properly and randomly check in with staff on reporting and intervening reports of abuse. Results will be reported by DON or designee to the monthly QAPI Meeting for 4 months or until the committee deems necessary. DON or designee will report the findings of these audits to each monthly QAPI meeting.	7/11/2025

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F 600	Continued From page 4 from the back, grabbed both of his forearms, lifted him off the floor by herself while he was fighting her, and placed him into the wheelchair forcefully. Her movements were quick and rough. She placed his wheelchair at the counter and locked his wheelchair brakes, which prevented him from moving his wheelchair. -CNA M, LPN J, and nutrition and food services supervisor L were all visible on the video footage present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *At 6:04 p.m., resident 1, positioned at the nurses' station, stood up from his wheelchair and fell to the floor. CNA D was seen from behind the wheelchair, extending resident 1's arms above his head as he lay on the floor. Without requesting assistance or notifying a nurse, CNA D then stood beside resident 1, placed her arms behind him, attempted to hoist him back into his wheelchair, and lifted him from the floor multiple times before seating him roughly into the wheelchair while he resisted her assistance. -CMA G, CNA H, and food service assistant E were all visible on the video footage and present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *At 6:12 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a third time. Without requesting assistance or notifying a nurse, CNA D lifted resident 1 from the floor and sat him roughly into the wheelchair while he resisted her assistance. -CMA I, CNA D, and food service assistant E were all visible on the video footage and present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *At 6:50 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and	F 600		

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F 600		F 600		

Continued From page 5

again fell to the floor for a fourth time. He was provided with a pillow, by a staff member and was not observed having been assessed by the nurse or assisted off the floor in that video footage. -He threw the pillow at the staff member and remained on the floor for approximately an hour. -CMA G, CNA K, CNA H, LPN J, and food service assistant E were all visible on the video footage and present in the area of the nurses' station, and did not intervene or offer assistance to resident 1. *CNA D's employment was terminated on 4/7/25 for her actions observed in the video footage immediately after the footage had been reviewed by management on 4/7/25.
*CNA K had been a contracted travel employee and was unavailable for interview. Her contract had ended.
*CNA H had been a contracted travel employee and was unavailable for interview. Her contract had been terminated due to another incident.
*LPN J had been a contracted travel employee and was unavailable for interview. She had terminated her contract three or four days after the incident with resident 1 on 4/6/25.

4. Interview on 6/12/25 at 8:42 a.m. with CMA Q revealed she had recently received training on "fall protocols," but did not recall any recent training on abuse and neglect. She completed abuse and neglect training when she was hired and annually online in the "Success Center."

5. Interview on 6/12/25 at 9:31 a.m. with LSW O regarding staff training and education revealed:
*Monthly "All Staff Meetings" were mandatory. -Employees were allowed to attend in person, by phone, via a "WebEX" (an online meeting platform) or were required to read and sign the attendance sheet before their next working shift.

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F 600		F 600		

Continued From page 6

*The monthly staff meeting binder was kept in the employee break room.
*New employee orientation and annual education were provided on the provider's online "Success Center."
-Those trainings were assigned "by corporate".
*Training was also provided in person, by text, and by email.

6. Interview on 6/12/25 at 1:07 p.m. with CMA G revealed she:
*Stated she had not worked on 4/6/25, the day that resident 1 had fallen four times.
*Did not recall any times that CNA D had been "rough" when providing care to resident 1.
*Had not attended any recent training on abuse, neglect, or falls.
*CMA G was seen in the video footage of 4/6/25 at 12:45 p.m., at 6:04 p.m., and at 6:51 p.m.

7. Interview on 6/12/25 at 2:19 p.m. with LSW O revealed she:
*Assisted with the completion of audits and had not been aware of any current audits of resident 1's care.
*Was unaware that the FRI had indicated, "Resident cares with [resident 1] will also be audited randomly for the next 2 months and then prn [as needed] to ensure appropriate interactions from staff."

8. Interview on 6/12/25 at 2:23 p.m. with DON B revealed:
*On 4/7/25 administrator A, DON B, director of finance N, and LSW O had reviewed the video footage of resident 1's 4/6/25 falls.
-They felt that the video was "embarrassing," and had shown "everything that should not have been done."

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F 600	Continued From page 7 --The footage revealed CNA D had been "really rough" with resident 1 and had locked his wheelchair while it was positioned at the nurse's station. --LPN J had been present on the video footage on 4/6/25 at 12:45 p.m. and 6:51 p.m. and had not assessed resident 1 after his falling incidents. *An assessment of resident 1 had been completed on 4/7/25 after review of the video by Minimum Data Set (MDS) registered nurse (RN) C and DON B, and they had confirmed that bruises on resident 1's forearms "correlated with" where CNA D had placed her hands while lifting resident 1 after his falls. *The video "verified abuse had occurred," and CNA D's agency [travel] employment contract had been terminated "immediately." *Education had been provided to LPN J on 4/7/25 on proper transfer techniques and completing a resident assessment after a fall. *In-person staff education was initiated on 4/7/25 on "not locking wheelchair brakes," ensuring an assessment was performed by a nurse before transferring a resident after a fall, and proper transfer techniques. *Education on resident abuse and neglect was provided through the online Success Center during orientation and annually. -There had not been any recent training provided on resident abuse and neglect. *Dementia training was ongoing, and a training was scheduled in July with the local ombudsman (resident rights advocate). *DON B expected CNA D to have: -Alerted the nurse when resident 1 fell. -Ensured that resident 1 had been assessed by the nurse before she transferred resident 1 back into his wheelchair. -Asked for assistance when transferring resident	F 600		

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F 600		F 600		

Continued From page 8

1.
-Requested another staff member to "take over" when she became frustrated with resident 1.
*DON B expected the other staff members identified as present when the incidents in the video occurred to have:
-Assisted when resident 1 fell.
-Stopped CNA D when she attempted to transfer resident 1 alone.
-Alerted the nurse when resident 1 fell to complete an assessment to ensure he was not injured.
-Attempted other interventions to prevent him from falling.
-Contacted him to report the incident.
*He was unaware that the FRI had indicated, "Resident cares with [resident 1] will also be audited randomly for the next 2 months and then prn [as needed] to ensure appropriate interactions from staff."

An interview with CMA I was requested and set up for 6/12/25 at 3:00 p.m. A voicemail was left, and no return call was received.

"All Staff training completed since 4/1/25, including materials provided and staff who attended, including any additional PRN training/education completed," was requested from administrator A and DON B during the survey entrance conference.

Review of the provider's staff training/education documentation since 4/1/25 revealed:
*"Education on Timeliness of DOH Reports" was provided to four employees between 4/28/25 and 5/5/25 and one employee on an undisclosed date.
*"Neuro [assessment of nervous system function] Vital [vital signs such as blood pressure,

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F 600	Continued From page 9 temperature, pulse, respirations, and blood oxygen level] Documentation (Falls)" education was provided to: -Two employees in December 2024. -Twelve employees in January 2025. -One employee in February 2025. -Two employees in March 2025. *A "Falls Investigation" packet did not identify the date the training was provided or include a signature sheet for attendance. *The provider's All Staff Meeting Binder revealed: - The 4/24/25 Care Center Monthly Meeting Agenda did not include education on the topics of abuse or neglect. -Out of 66 employees, 33 had attended the meeting or signed that they had reviewed the information in the binder. *The 5/30/25 Care Center Monthly Meeting Agenda did not include education on the topics of abuse or neglect. -Out of 45 employees, 18 had attended the meeting or signed that they had reviewed the information in the binder. *The provider's "In Person Dementia Training" education staff attendance sheets from 1/8/25 through 5/27/25 did not include documentation of the content of the education provided in that training. *The provider's "Ombudsman Dementia Training" education staff attendance sheets from 1/28/25 through 5/29/25 did not include documentation of the content of the education provided in that training. *LPN J received training on 4/7/25 on "proper assessment techniques after a resident fall," that included resident 1 "should have been helped back up to his wheelchair immediately after [an] assessment [of the resident had been completed], not left to lay on the floor...for nearly	F 600		

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F 600		F 600		

Continued From page 10 an hour," and
"ensuring brakes are not locked on wheelchair that is a restraint ..."
-That training did not include resident abuse and neglect."
*Education dated 4/7/25 included "notify the nurse immediately so they can assess the resident for injury," and "brakes also should not be locked when a resident's wheelchair is stationary, that is considered a restraint," was provided to 26 employees between 4/7/25 and 4/18/25. -Food service assistant E, nutrition and food services supervisor L, and CNA M had not received that education.

Interview on 6/12/25 at 4:00 p.m. with executive assistant P regarding abuse and neglect training revealed:
*Abuse and neglect training was provided to staff on the "Success Center" online learning platform.
*CNA D was a contracted travel employee from 2/24/25 until 4/8/25 and had not received abuse and neglect training.
*CNA H was a contracted travel employee from 4/2/25 until 4/14/25 and had not received abuse and neglect training.
*CNA K was a contracted travel employee from 2/26/25 until 5/24/25 and had not received abuse and neglect training.
*LPN J was a contracted travel employee from 2/13/25 until 4/9/25 and had not received abuse and neglect training.
*Food service assistant E was hired on 8/23/21. Executive assistant P was unable to find documentation that food service assistant E had received abuse and neglect training.
*Nutrition and food services supervisor L was hired on 9/19/11. Executive assistant P was unable to find documentation that nutrition and food services supervisor L had received abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 600		F 600		

Continued From page 11

and neglect training.

*CNA M was hired on 2/19/25 and received abuse and neglect training on 2/20/25.
*CMA G was hired on 5/28/19 and had received abuse and neglect training on 3/8/25.
*CMA I was hired on 3/18/24 and received abuse and neglect training on 2/4/25.

Review of the provider's 7/10/24 Abuse and Neglect policy revealed:
*"Patients and residents have the right to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of property, corporal punishment, exploitation and involuntary seclusion."
*"Patients and residents must not be subject to any kind of abuse by anyone, but not limited to, facility staff, other patients or residents, consultants, volunteer staff or other agencies serving the individual, family members, legal guardians or personal representatives, friends, or other individuals."
*"Abuse means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial wellbeing. This presumes that instances of abuse of all patients and residents even those in a coma, cause physical harm or pain or mental anguish."
*"Physical Abuse includes...restraining or confining a patient/resident to control behavior..."
*Policy "To require facility staff to report suspected abuse or neglect of vulnerable adults."
*"All persons who have reasonable cause to believe a resident/patient of this facility is being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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

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F 600	Continued From page 12 subjected to abuse and/or neglect...are responsible to report such suspicions."	F 600		
F 657 SS=E	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 South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interview, and policy review, the provider failed to ensure care plans were reviewed and	F 657	1. Corrective action to residents affected: a. Education with nurses was reinforced on how to update care plans by MDS Coordinator starting on 6/13/25 and will continue to be reiterated to ensure they are retaining this information. A step by step guide will be provided and placed at each nurses' station. This education will be completed by 7/11/25. MDS coordinator or designee will ensure this education is completed. b. IDT team to review care plans in MDS review for the 2 week ARD window period biweekly x 3 months. 2. Identify other Potential Residents Affected: a. All other residents can be affected if the following measures are not taken: i. Ensuring that nursing staff are properly trained and retaining education on updating care 3. Measures put into place or Systemic Changes made to ensure this will not reoccur: a. IDT team to review care plans in MDS review for the 2 week ARD window period regularly to ensure care plan updates are being completed. i. IDT Team consists of DON, MDS Coordinator, LSW, Admin Assistant, Activities Director, CEO, RN and Quality/Risk RN. (Continued on Page 14)	7/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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

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F 657	Continued From page 13 revised to reflect the current care needs for two of two sampled residents (1 and 2). Findings include: 1. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on 7/25/23. *His 3/28/25 Minimum Data Set (MDS) assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *His diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (a mental state where a person loses touch with reality), mood disturbance (a serious mental illness that causes persistent and intense changes in a person's mood energy and behavior), general anxiety disorder, Alzheimer's Disease, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), and conduct disorder (a mental health condition that involves a persistent pattern of aggressive and antisocial behavior). *Resident 1 experienced 15 falls between 3/11/25 and 5/7/25. *Five of resident 1's falls occurred on or before 4/6/25. Review of resident 1's Fall Risk Assessments indicated: *On 4/6/25, he had a high risk for falls, and a referral to a "Falls Prevention Program" may be appropriate, and "Continue Current Plan of Care" were marked. -Resident 1 fell four times between 4/7/25 and 4/15/25. *On 4/15/25, he had a high risk for falls, and "No Referrals Necessary," and "Continue Current	F 657	4. Monitor Process for the system change including frequency and person responsible: a. DON or designee will monitor care plans with each MDS for 1 month. Then 5 random MDS' monthly for 4 months. Results will be reported by DON or designee to the monthly QAPI meeting for 4 months or until the committee deems necessary. b. IDT team to review care plans in MDS review for the 2 week ARD window period biweekly x 3 months. Results will be reported by DON or designee to the monthly QAPI meeting for 4 months or until the committee deems necessary.	7/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657		F 657		

Continued From page 14

Plan of Care" were marked.
-Resident 1 fell four times between 4/16/25 and 4/26/25.
*On 4/26/25, he had a high risk for falls, and a referral to a "Falls Prevention Program" may be appropriate, and "Continue Current Plan of Care" were marked.
-Resident 1 fell two times between 4/27/25 and 5/7/25.
*On 5/7/25, he had a high risk for falls, and a referral to a "Falls Prevention Program" may be appropriate, and "Plan of Care Updated," and "safety signs in room" were marked.
-At least eight of resident 1's falls occurred outside of his room.

Review of resident 1's fall incident reports and interventions implemented to prevent subsequent falls revealed:
*On 4/6/25 at 12:40 p.m., staff were to keep resident 1 in "Line of sight for the next couple of hours."
*On 4/6/25 at 6:10 p.m., 6:15 p.m., and 6:20 p.m., 4/14/25 at 11:40 a.m., and 12:25 p.m., no documented interventions were put in place.
*On 4/15/25 at 11:00 a.m. and 4:00 p.m., "UNKNOWN" was indicated.
*On 4/16/25, resident 1 was "agitated and left alone on floor with [a] pillow per [his] care plan." -No other documented intervention was put in place at that time to prevent him from subsequent falls.
*On 4/26/25, "We let resident [1] lay on the floor until he was ready to get up" was documented. -No other intervention was put in place at that time to prevent him from subsequent falls. -On 5/7/25 at 2:45 p.m., "Safety signs placed" was documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657		F 657		

Continued From page 15

Review of resident 1's Post-Fall Investigation Tool "Recommendations for future prevention" revealed:
*On 4/14/25 at 11:40 a.m. and 12:25 p.m., 4/15/25 at 4:00 p.m., 4/16/25, 4/18/25, 4/26/25, 4/22/25, and 5/5/25 that section had not been completed.
*On 4/15/25 at 11:00 a.m. "Quit isolating dementia Pts [patients]" was documented.
*On 5/7/25, "Signs in room" was documented.

Review of resident 1's care plan revealed: *A problem area indicated "Falls [resident 1] at risk for falling R/T [related to] dementia, incontinence, and ambulatory status" was last reviewed/revised on 4/24/25.
-A 5/7/25 "Approach" (intervention) indicated "Posted signs or pictures to cue [resident] for toileting /assistance prior to [the resident] getting up."
-A 4/7/25 "Approach" indicated "Provide toileting assistance every 2-3 [two to three] hrs [hours] while awake and PRN [as needed]."
--Resident 1 was "Dependent [on the] assistance x2 [of two staff members] for walking on/off unit." --Resident 1 was "Able to pedal [his wheelchair] with [his] feet [for] short distances."
--Resident 1 was "Dependent [on the] assistance x 1-2 [of one to two staff members]" for toileting.
*Resident 1's care plan had not been updated with fall prevention interventions after falling incidents that occurred between 4/7/25 and 5/7/25. He had experienced nine falls during that time.

Resident 1 was out of the facility and unavailable for an interview throughout the survey.

2. Review of the provider's 6/1/25 SD DOH FRI

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657		F 657		

Continued From page 16

revealed:

*"[Resident 2] was found on [the] floor at 1910 [7:10 p.m.] by a CNA ...he was attempting to self transfer out of wheelchair by [his room]."
*Resident 2 sustained a "closed fracture of [his] left hip."
*Before the fall, resident 2 "was changed from [needing to use] a stand aid [a mechanical device that lifts a resident from a sitting position to a standing position] to a stand pivot with two [staff] assist [assistance]."

Observation and interview on 6/11/25 at 11:10 a.m. with resident 2 revealed:
*He was seated in his recliner, fully reclined, holding a cup of water with a straw.
*He answered questions with one to two words, smiled, and laughed.
*There was no air mattress overlay on his bed.

Review of resident 2's EMR revealed: *He was admitted on 11/11/21 and received hospice services from 2/17/25 until 5/10/25.
*Resident 2 had been evaluated by physical therapy (PT) on 5/15/25.
*His 5/23/25 MDS assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *A 5/27/25 PT progress note indicated "...will change program to add SPT [stand pivot transfer] in addition to stand aid until all staff [are] more comfortable with transfer and staff are aware." *Resident 2 fell on 5/29/25.
*A 5/29/25 Fall Risk Assessment indicated resident 2 was "Not at Risk" for falls and to "Continue with Plan of Care.
*His 5/29/25 fall incident report did not indicate any interventions were implemented or revised to prevent subsequent falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657		F 657		

Continued From page 17

*Resident 2's Post-Fall Investigation Tool "Recommendations for future prevention" revealed "toilet more frequently."
-His care plan was not updated to include that intervention.
*Resident 2 fell on 6/1/25 and sustained a closed fracture of his left hip and was hospitalized. *He was readmitted to the facility on 6/5/25 and admitted to Hospice Services that same day.

Review of resident 2's current care plan revealed:
*A 3/5/25 last reviewed/revised problem area of "ADL's Functional Status" with approaches that indicated:
Transfers "Dependent x2 [on the assistance of two staff members] for transfers using [a] Hoyer lift [a mechanical lift and sling used to lift a person's full body] to/from toilet, recliner..."
*A 3/5/25 last reviewed/revised problem area of "Falls [resident 2] has a history of falling and is at risk for injury from fall" with "Approaches" that indicated:
"Posey bed alarm system activated while in bed."
"Keep bed in low position."
"Provide proper, well-maintained footwear."
"Provide resident [2] an environment free of clutter."
*A 2/17/25 initiated problem area "Terminal Care [resident 2] is on [provider name] Hospice d/t [due to] terminal prognosis of Alzheimer's Disease.
That was last reviewed/revised on 3/14/25 with an approach that indicated:
-"Air mattress overlay ...to prevent skin breakdown while in bed."
*His care plan had not been updated to indicate: -His transfer status had changed to a stand pivot transfer on 5/27/25.
Any new or revised fall prevention interventions after his 5/29/25 fall.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657		Continued From page 18 He had been admitted to hospice services on 6/5/25. He did not have an air mattress overlay on his bed. 3. Interview on 6/11/25 at 2:08 p.m. with CNA R regarding resident 2 revealed: *Resident 2 was on hospice. *CNA R used the care plan located in the EMR system to know how to care for resident 2. 4. Observation and interview on 6/12/25 at 8:42 a.m. with resident 2 and CNA Q revealed: *CNA Q confirmed resident 2 did not have an air mattress or overlay on his bed. -She indicated he had one when he had previously received hospice services, but it had been removed. *CNA Q used the care plan in their EMR system to know how to care for resident 2. 5. Phone interview on 6/12/25 at 11:19 a.m. with registered nurse (RN) F revealed: *After a resident fell, the staff members on duty would have a "post-fall huddle" to discuss the fall and how to prevent further falls (interventions). *The "post-fall sheet" had a place to indicate new interventions. *Minimum Data Set (MDS) RN C updated the care plans. *A list of fall interventions had been posted at the nurses' station "recently," and nurses had been told that they needed to update the residents' care plans after each fall. *He had not received education on how to update the care plan. *He would email MDS RN C to let her know if they had tried a new intervention. *He would look in the residents' EMR for their	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657		F 657		

Continued From page 19 care plans, but he was not sure where the CNAs would find the interventions since they had stopped using pocket care plans (a portable document that outlines a resident's care needs).

6. Interview on 6/12/25 at 1:35 p.m. with MDS RN C regarding resident care plans revealed:
*Each department was responsible for its portion of a resident's care plan.
*She updated the nursing sections of the resident's care plan when she completed the MDS and expected all nurses to update the care plans as changes occurred.
*Staff had been educated on updating care plans in January 2025.
*She had posted a laminated list of fall interventions at each nurse's station for the nurses to reference when they updated the resident care plans after a fall.
*She expected that resident 2's care plan would have been updated when he was discharged from hospice services in May.
*She expected the resident care plans to be updated "in real time" to reflect the resident's current care needs.
*She acknowledged that resident 1 and 2's care plans did not reflect their current care needs.

7. Interview on 6/12/25 at 2:23 p.m. with director of nursing (DON) B regarding resident care plans revealed he expected care plans to be updated to reflect the resident's current care needs.

Review of the provider's 1/31/25 Comprehensive Care Plan and Care Conferences policy revealed: *"To develop a person-centered care plan for each resident that includes measurable objectives and timetables to meet his or her physical, mental, spiritual and psychosocial

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 657	Continued From page 20 well-being." *"The care plan is driven by identified resident issues/conditions and their unique characteristics, strengths and needs. When implemented in accordance with the standards of good clinical practice, the care plan becomes a powerful, practical tool representing the best approach to providing quality of care and quality of life." *"Person-centered care - To focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives." *"...The care plans must be revised as the resident's needs/status changes."	F 657		
F 689 SS=G	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) review, observation, record review, and interview, the provider failed to implement, review and revise interventions to reduce the risk of falls for two of two sampled residents (1 and 2) with a history of falls and to prevent subsequent falls. Findings Include: 1. Review of the provider's 6/1/25 SD DOH FRI revealed:	F 689	1. Corrective action to residents affected: a. Fall intervention list implemented and placed at each nurses' station by MDS Coordinator on 6/13/25 and nurses have been educated that they must update care plans with new intervention(s) after each fall. b. Revised and updated post fall checklists and Fall Scene Huddle worksheets to be implemented by MDS Coordinator or desginee for nurses to complete after each fall. This will be in place by 7/11/25. c. Nurses were educated by MDS Coordinator or designee on properly filling out fall acuity observation in EHR at the LTC Staff meeting on 6/26/25 d. Education with nurses by MDS Coordinator or designee was reinforced on how to update care plans starting on 6/13/25 and will continue to be reiterated to ensure they are retaining this information. A step by step guide will be provided and placed at each nurses' station by the MDS Coordinator. This education will be completed by 7/11/25 by MDS, RN and will be monitored for completion by MDH, RN or designee. (Continued on Page 22)	7/11/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689	Continued From page 21 *"[Resident 2] was found on [the] floor at 1910 [7:10 p.m.] by a CNA [certified nursing assistant]...he was attempting to self transfer out of wheelchair by [his room]." *Resident 2 sustained a "closed fracture of [his] left hip." *Before the fall, resident 2 "was changed from [needing to use] a stand aid [a mechanical device that lifts a resident from a sitting position to a standing position] to a stand pivot with two [staff] assist [assistance]." Interview and review of the 6/1/25 video footage on 6/12/25 at 10:12 a.m. with director of finance N, director of nursing (DON) B, and licensed social worker (LSW) O revealed: *Resident 2 was seated in his wheelchair by certified medication assistant (CMA) G at her medication cart two minutes before he fell. *CMA G entered a resident's room across from her medication cart, and resident 2 propelled himself in his wheelchair down the hall. Used the railing in the hallway, stood from his wheelchair, took approximately six to eight small steps, and fell. *Registered nurse (RN) F responded and provided care to resident 2. Review of resident 2's electronic medical record (EMR) revealed: *He was admitted on 11/11/21 and received hospice services from 2/17/25 until 5/10/25. *Resident 2 had been evaluated by physical therapy (PT) on 5/15/25. *His 5/23/25 MDS assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired. *A 5/27/25 PT progress note indicated " ...will change program to add SPT [stand pivot transfer]	F 689	2. Identify other residents affected: a. All other residents can be affected if the following measures are not taken: i. Ensuring that nursing staff are properly trained and retaining education on updating care plans with each fall ii. Ensuring that nursing staff are utilizing and accurately completing the revised post fall checklist and fall scene huddle worksheet iii. Ensuring that nursing staff are completing the fall acuity observation in the EHR with each fall 3. Measures put into place or systemic changes made to ensure this will not reoccur: a. Updated Fall Scene Huddle Worksheet with each fall b. Updated Post Fall Checklist with each fall c. List of interventions provided to nursing staff (by nurses station) to update care plans with each fall that occurs d. Education was started on 6/13/25 to nurses on how to properly fill out the fall acuity observation in the EHR. 4. Monitor Process for the system change including frequency and person responsible: a. DON or designee will monitor that updated fall scene huddle worksheet and checklist are completed with each fall for 1 month. Then 5 random falls monthly for 4 months. Results will be reported by DON or designee to the monthly QAPI meeting for 4 months or until the committee deems necessary. b. MDS or designee will monitor care plans for new fall interventions being added with each fall that occurs for 1 month. Then 5 random falls monthly for 4 months. Results will be reported by DON or designee to the monthly QAPI meeting for 4 months or until the committee deems necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689		F 689		

Continued From page 22

in addition to stand aid until all staff [are] more comfortable with transfer and staff are aware."
*Resident 2 fell on 5/29/25.
*A 5/29/25 Fall Risk Assessment indicated resident 2 was "Not at Risk" for falls and to "Continue with Plan of Care.
*His 5/29/25 fall incident report did not indicate any interventions were implemented or revised to prevent subsequent falls.
*Resident 2's Post-Fall Investigation Tool "Recommendations for future prevention" revealed "toilet more frequently."
-His care plan was not updated to include that intervention.
*Resident 2 fell on 6/1/25 and sustained a closed fracture of his left hip and was hospitalized. *He was readmitted to the facility on 6/5/25 and admitted to Hospice Services that same day.

Review of resident 2's current care plan revealed:
*A 3/5/25 last reviewed/revised problem area of "ADL's Functional Status" with approaches that indicated:
Transfers "Dependent x2 [on the assistance of two staff members] for transfers using [a] Hoyer lift [a mechanical lift and sling used to lift a person's full body] to/from toilet, recliner..."
*A 3/5/25 last reviewed/revised problem area of "Falls [resident 2] has a history of falling and is at risk for injury from fall" with "Approaches" that indicated:
"Posey bed alarm system [a device used to alert caregivers when a resident attempts to exit their bed, designed to help prevent falls] activated while in bed."
"Keep bed in low position."
"Provide proper, well-maintained footwear."
"Provide resident [2] an environment free of clutter."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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

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F 689		F 689		

Continued From page 23

*A 2/17/25 initiated problem area "Terminal Care [resident 2] is on [provider name] Hospice d/t [due to] terminal prognosis of Alzheimer's Disease. That was last reviewed/revised on 3/14/25 with an approach that indicated:
-"Air mattress overlay ...to prevent skin breakdown while in bed."
*His care plan had not been updated to indicate: - His transfer status had changed to a stand pivot transfer on 5/27/25.
Any new or revised fall prevention interventions after his 5/29/25 fall.
He had been admitted to hospice services on 6/5/25.
He did not have an air mattress overlay on his bed.

2. Interview and review of the 4/6/25 video footage on 6/12/25 at 10:12 a.m. with director of finance N, DON B, and LSW O revealed:
*Resident 1 fell on 4/6/25 at 12:45 p.m., 6:04 p.m., 6:12 p.m., and at 6:51 p.m.
*At 12:45 p.m., resident 1 stood up from his Broda Pedal Wheelchair (a specialized high-back reclining wheelchair with upper body support that allows a person to self-propel with their hands or feet) that was positioned at the counter in front of the nurses' station. CNA D approached resident 1. Resident 1 swung his arm at her. CNA D stepped back, and resident 1 fell to the floor. - Without requesting assistance or notifying a nurse, CNA D reached around resident 1 and, from the back, grabbed both of his forearms, lifted him off the floor by herself while he was fighting her, and placed him into the wheelchair forcefully. Her movements were quick and rough. She placed his wheelchair at the counter and locked his wheelchair brakes, which prevented him from moving his wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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

(X4) 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
F 689		F 689		

Continued From page 24

*At 6:04 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and fell to the floor. CNA D was seen from behind the wheelchair, extending resident 1's arms above his head as he lay on the floor. Without requesting assistance or notifying a nurse, CNA D then stood beside resident 1, placed her arms behind him, attempted to hoist him back into his wheelchair, and lifted him from the floor multiple times before seating him roughly into the wheelchair while he resisted her assistance. *At 6:12 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a third time. Without requesting assistance or notifying a nurse, CNA D lifted resident 1 from the floor and sat him roughly into the wheelchair while he resisted her assistance.
*At 6:50 p.m., resident 1, still positioned at the nurses' station, stood up from his wheelchair and again fell to the floor for a fourth time. He was provided with a pillow, by a staff member and was not observed having been assessed by the nurse or assisted off the floor in that video footage.
*After each fall observed on that video footage, resident 1 was returned to his wheelchair and positioned facing the counter at the nurses' station. No new interventions were implemented to prevent subsequent falls.

Review of resident 1's EMR revealed:
*He was admitted on 7/25/23.
*His 3/28/25 MDS assessment indicated he was rarely understood or able to understand others and was severely cognitively impaired.
*His diagnosis included dementia (a group of symptoms affecting memory, thinking and social abilities), psychotic disturbance (a mental state where a person loses touch with reality), mood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689		F 689		

Continued From page 25 disturbance (a serious mental illness that causes persistent and intense changes in a person's mood energy and behavior), general anxiety disorder, Alzheimer's Disease, Parkinson's disease (a disorder of the central nervous system that affects movement often including tremors), and conduct disorder (a mental health condition that involves a persistent pattern of aggressive and antisocial behavior).
*Resident 1 experienced 15 falls between 3/11/25 and 5/7/25.
*Five of resident 1's falls occurred on or before 4/6/25.

Review of resident 1's Fall Risk Assessments indicated:
*On 4/6/25, he had a high risk for falls, and a referral to a "Falls Prevention Program" may be appropriate, and "Continue Current Plan of Care" were marked.
-Resident 1 fell four times between 4/7/25 and 4/15/25.
*On 4/15/25, he had a high risk for falls, and "No Referrals Necessary," and "Continue Current Plan of Care" were marked.
-Resident 1 fell four times between 4/16/25 and 4/26/25.
*On 4/26/25, he had a high risk for falls, and a referral to a "Falls Prevention Program" may be appropriate, and "Continue Current Plan of Care" were marked.
-Resident 1 fell two times between 4/27/25 and 5/7/25.
*On 5/7/25, he had a high risk for falls, and a referral to a "Falls Prevention Program" may be appropriate, and "Plan of Care Updated," and "safety signs in room" were marked.
-At least eight of resident 1's falls occurred outside of his room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689		F 689		

Continued From page 26

Review of resident 1's fall incident reports and interventions implemented to prevent subsequent falls revealed:
*On 4/6/25 at 12:40 p.m., staff were to keep resident 1 in "Line of sight for the next couple of hours."
*On 4/6/25 at 6:10 p.m., 6:15 p.m., and 6:20 p.m., 4/14/25 at 11:40 a.m., and 12:25 p.m., no documented interventions were put in place.
*On 4/15/25 at 11:00 a.m. and 4:00 p.m., "UNKNOWN" was indicated.
*On 4/16/25, resident 1 was "agitated and left alone on floor with [a] pillow per [his] care plan." -No other documented intervention was put in place at that time to prevent him from subsequent falls.
*On 4/26/25, "We let resident [1] lay on the floor until he was ready to get up" was documented. -No other intervention was put in place at that time to prevent him from subsequent falls. -On 5/7/25 at 2:45 p.m., "Safety signs placed" was documented.

Review of resident 1's Post-Fall Investigation Tool "Recommendations for future prevention" revealed:
*On 4/14/25 at 11:40 a.m. and 12:25 p.m., 4/15/25 at 4:00 p.m., 4/16/25, 4/18/25, 4/26/25, 4/22/25, and 5/5/25 that section had not been completed.
*On 4/15/25 at 11:00 a.m. "Quit isolating dementia Pts [patients]" was documented.
*On 5/7/25, "Signs in room" was documented.

Review of resident 1's care plan revealed: *A problem area indicated "Falls [resident 1] at risk for falling R/T [related to] dementia, incontinence, and ambulatory status" was last

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689		F 689		

Continued From page 27

reviewed/revised on 4/24/25.

-A 5/7/25 "Approach" (intervention) indicated "Posted signs or pictures to cue [resident] for toileting /assistance prior to [the resident] getting up."
-A 4/7/25 "Approach" indicated "Provide toileting assistance every 2-3 [two to three] hrs [hours] while awake and PRN [as needed]."
--Resident 1 was "Dependent [on the] assistance x2 [of two staff members] for walking on/off unit." --Resident 1 was "Able to pedal [his wheelchair] with [his] feet [for] short distances."
--Resident 1 was "Dependent [on the] assistance x 1-2 [of one to two staff members]" for toileting.
*Resident 1's care plan had not been updated with interventions to reduce his risk for falls after he fell nine times between 4/7/25 and 5/7/25.

3. Phone interview on 6/12/25 at 11:19 a.m. with RN F revealed:
*Resident 1 had "many" falls.
*He was the nurse on duty when resident 2 fell on 6/1/25.
*CMA G had been with resident 2 just before he fell and had called him to assess resident 2 after he fell on 6/1/25.
*After a resident fell, the staff members on duty would have a "post-fall huddle" (meeting) to discuss the fall and how to prevent further falls.
*The "post-fall sheet" had a place to indicate new interventions.
*A list of fall interventions had been posted at the nurses' station "recently," and nurses had been told that they needed to update the residents' care plans after each fall.
*He had not received education on how to update the care plan.
*He would email MDS RN C to let her know if they had tried a new intervention.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689		F 689		

Continued From page 28

*He would look in the residents' EMR for their care plans, but he was not sure where the CNAs would find the interventions since they had stopped using pocket care plans (a portable document that outlines a resident's care needs).

4. Interview on 6/12/25 at 1:07 p.m. with CMA G revealed she:
*Had not attended any recent training on preventing falls.
*Had worked on 6/1/25 when resident 2 fell.
*Recalled resident 2 had been with her at her medication cart at the end of the hall. The resident in the room across from her was standing in his room. She entered that resident's room to assist that resident and heard resident 2 fall.
*She had only been away from resident 2 a couple of minutes before he fell.
*She was unsure how resident 2 transferred or when he had been last used the bathroom before his fall.
*The nurse would give a verbal a report, or the CNAs would do "walking rounds" to share resident status information.
*She does not look at the care plan in the EMR and was not sure where to locate resident fall interventions.

5. Interview on 6/12/25 at 1:35 p.m. with MDS RN C regarding resident fall interventions revealed:
*She had posted a laminated list of fall interventions at each nurse's station for nurses to reference when they updated the resident care plans after a fall.
*She expected new interventions to be implemented and added to the resident care plans "in real time" after a resident's fall to reduce the resident's risk for falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 06/12/2025

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) COMPLETION DATE
F 689	Continued From page 29 6. Interview on 6/12/25 at 2:23 p.m. with DON B regarding fall interventions revealed he expected care plans to be updated with new fall interventions after a resident had a fall to reduce the resident's risk for falls. Review of the provider's 3/1/24 Fall Prevention & Follow-Up Reporting policy revealed: *"The interdisciplinary team will review and discuss [fall] preventatives at weekly Mini-Managers meetings." *"The QMI [quality management and improvement Committee will review resident falls every month to determine what new, preventative [fall] measures [interventions] should be put in place."	F 689		