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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433507	A. BUILDING _____ B. WING _____	08/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MEDICAL CENTER	323 SW 10TH ST MADISON, SD 57042

(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
V 000	INITIAL COMMENTS A Recertification (CORE) survey was conducted by Healthcare Management Solutions, LLC on behalf of Centers for Medicare & Medicaid Services (CMS). An unannounced on-site Recertification (CORE) survey (ASPEN #39UU11) conducted at the above-named End Stage Renal Disease (ESRD) facility from 08/23/23 to 08/25/23 resulted in a finding of substantial compliance respective to applicable Conditions for Coverage (CfC) under 42 CFR 494, Subpart A through D. Total Facility Census: 7 In-Center Hemodialysis: 7 Home Hemodialysis (HHD): 0 Peritoneal Dialysis (PD): 0 Nocturnal: 0 Pediatrics: 0 Sample Size: 5 Network 11 was contacted after entrance.	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Twyla Nordquist, BSN, RN, CNN | Dialysis Director | 9/12/2023

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 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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E 000	Initial Comments A Recertification (CORE) Survey was conducted by Healthcare Management Solutions, LLC on behalf of Centers for Medicare & Medicaid Services (CMS). An unannounced on-site Recertification (CORE) survey (ASPEN #39UU11) conducted at the above-named End Stage Renal Disease (ESRD) facility from 08/23/23 to 08/25/23 resulted in a finding of no deficiency respective to the Emergency Preparedness Program Condition for Coverage under 42 CFR 494.62. Survey Dates: 08/23/23 to 08/25/23 Total Facility Census: 7 In-Center Hemodialysis: 7 Home Hemodialysis (HHD): 0 Peritoneal Dialysis (PD): 0 Nocturnal: 0 Pediatrics: 0 Sample Size: 5 Network 11 was contacted after entrance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Twyla Nordquist, BSN, RN, CNN | Dialysis Director | 9/12/2023

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