STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	431329	A. BUILDING _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN MEDICAL CENTER	300 S BYRON 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
C 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.601-485.649, requirements for Critical Access Hospitals (CAH) was conducted from 7/14/25 through 7/16/25. Sanford Chamberlain Medical Center was found not in compliance with the following requirements: C1046 and C1210.	C 000		
C1046	NURSING SERVICES CFR(s): 485.635(d)(1) Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure the patient's nutritional needs were assessed and documented for two of two sampled obstetric patients (1 and 2) according to the provider's policy. Findings include: 1. Review of patient 7's electronic medical record (EMR) revealed: *She was admitted on 7/10/25 to the labor and delivery unit. *The admission navigator (an admission assessment tool) questions for an obstetric (OB) patient had been completed on 7/10/25. *A nutrition assessment had not been completed during her hospitalization.	C1046	Revisions to Patient Nutrition Assessment and Screening – Chamberlain policy The adult admission navigator will be utilized for all medical/surgical patients. Nutrition areas to be addressed include: unable to eat > 3 days, pressure ulcer, unintended weight loss> 10#, problems chewing or on enteral or parental nutrition, chokes on food or liquid, lactating (not on OB floor). The OB admission navigator will be utilized by all OB patients. Nutritional areas to be addressed include: is current weight lower than pre-pregnancy weight, multi-gestation pregnancy, hyperemesis diagnosis & high risk OB. Policy changes completed 8/1/25. Education to nursing staff on policy revisions completed 8/30/25. OB manager or designee will review all OB admissions charts for nutrition assessment within 48 hours of admissions X 4 months. Results will be reported by OB manager or designee to the monthly QAPI meeting for 4 months or until the committee deems necessary.	8/30/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Erica Peterson	Admnistrator/CEO	8/4/2025

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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C1046	Continued From page 1 2. Review of patient 4's EMR revealed: *She was admitted on 7/13/25 to the labor and delivery unit. *The OB admission navigator had been completed on 7/13/25. *A nutrition assessment had not been completed during her hospitalization. 3. Interview on 7/16/25 at 2:30 p.m. with OB manager D regarding nutrition assessments for OB patients revealed: *Staff would have completed the OB admission navigator upon a patient's admission to the facility. *She agreed a nutrition assessment had not been included with the OB admission navigator questions and should have been completed. *OB manager D stated all OB patients had not had a nutrition assessment completed. 4. Interview on 7/16/25 at 4:30 p.m. with registered nurse (RN) C regarding the OB admission navigator questions revealed: *She would have completed the OB admission navigator with a patient upon the patient's admission to the facility. *She agreed there was no nutrition assessment in the OB admission navigator and should have been completed. Review of the provider's July 2024 Patient Nutrition Assessment and Screening policy revealed: *"Nursing will screen patients within 24 hours of admission and record information in the EMR." *"The admission navigator will be utilized for each patient. Nutrition areas to be addressed include:" "-Unable to eat for 3 days."	C1046		

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C1046	Continued From page 2 -"Unintended weight loss > 10 pounds." -"High Risk OB."	C1046		
C1210	INFECTION PREVENT & CONTROL SCOPE & SEVERITY CFR(s): 485.640(a)(4) The infection prevention and control program reflects the scope and complexity of the CAH services provided. This STANDARD is not met as evidenced by: Based on observation and interview the provider failed to follow infection control practices to ensure: *There was sufficient exhaust air flow for one of one decontamination room. *Six of fifteen medical-surgical equipment items were free of rust in the operating room (OR). Findings include: 1. Observation on 7/15/25 at 9:30 a.m. revealed air from inside the decontamination room was flowing through the door into the hallway. Observation and interview on 7/15/25 at 9:35 a.m. with surgical technologist G revealed: *She confirmed the air was coming out of the decontamination room and into the hallway. *She had noticed the air coming out of the decontamination room a while ago. *She agreed that the decontamination room should have been negatively pressured. Observation and interview on 7/16/25 at 3:45 p.m. with maintenance director H revealed: *He was not aware the decontamination room was positively pressured. *The decontamination room pressurization was adjusted and balanced on 7/24/24 by a	C1210	Airflow in decontamination room was corrected by replacing a damper that wasn't opening correctly- completed 7/31/25. Implemented Maintaining Environmental Control for a Negative Isolation – Chamberlain policy to maintain and monitor federal and state requirements for airflow and room pressure for isolation rooms, completed 8/4/25. Maintenance, OR and laundry staff education on policy completed 8/30/25. Maintenance manager or designee will check airflow in decontamination room to ensure it is negatively pressured weekly for 1 month then bi-weekly for 3 months. Results will be reported by maintenance manager or designee to the monthly QAPI meeting x 4 months or until the committee deems necessary. All wheels and equipment with rust where removed from service and rusted wheels replaced on 7/30/25. Education given on 7/17/25 to OR staff to immediately remove rusted equipment from service. Education to nursing staff to immediately remove rusted equipment from service completed 8/30/25. Added Removing equipment with rust from service under Cleaning and Disinfecting in Environmental Services Infection Control – Chamberlain policy. Completed 8/30/25.	8/30/25

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C1210	Continued From page 3 contracted company. *Maintenance staff had not checked the airflow in the decontamination room since it was last balanced on 7/24/24. *He agreed that the decontamination room should have been negatively pressured. *He was unsure of how long the decontamination room had been positively pressured. A policy regarding air flow for the decontamination room was requested on 7/16/25 at 3:45 p.m. The provider had been unable to provide the requested policy by the end of the survey. 2. Observation in the OR on 7/16/25 at 7:45 a.m. revealed: *Three IV poles had rust on the legs and casters. *Two metal tables had rust on the legs and casters. *One ring stand had rust on the casters. Interview on 7/16/25 at 7:50 a.m. with surgical technologist G revealed: *She confirmed the equipment items above contained rust and were not cleanable surfaces. *Equipment containing rust should not have been used or available for use in the OR. Interview on 7/16/25 at 9:35 a.m. with OR manager D regarding the rusted equipment items in the OR and the decontamination room revealed: *She had been aware of the rusted equipment in the OR and scope room. *The maintenance employees had been working on removing the rust from the equipment, but had to stop to attend to other projects. *She had thought a rusted surface would have been a cleanable surface, but she had not	C1210	IP or designee will spot check 5 pieces of equipment for rust weekly for 1 month then twice weekly for 3 months to ensure equipment is rust free. Results will be reported by IP or designee to the monthly QAPI meeting x 4 months or until the committee deems necessary.	8/30/25

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C1210	Continued From page 4 researched the issue. *OR manager D had not been aware that the decontamination area for surgical instruments required a negative airflow. Interview on 7/16/25 at 10:00 a.m. with infection control coordinator B regarding the cleanability of a rusted surface revealed he had thought a rusted surface was uncleanable. Interview on 7/16/25 at 3:15 p.m. with discharge planner E regarding rusted equipment revealed: *Staff had placed rusted equipment in her office for removal from use. *She agreed if equipment was rusted, it was not cleanable and should have been removed from use. Interview on 7/16/25 at 3:55 p.m. with director of nursing (DON) A regarding rusted equipment revealed: *She agreed rusted equipment should have been removed from use. *DON A had not been aware that there was rusted equipment in the OR and the scope room that had remained in use. Request for a policy on the removal of equipment from service had been requested, but the provider did not have a policy that indicated rusted equipment should have been removed from service.	C1210		

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K 000	INITIAL COMMENTS A recertification survey was conducted on 7/15/25 for compliance with 42CFR 485.623(d)(1), requirements for critical access hospitals (and swing bed). Sanford Chamberlain Medical Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K0211, K0223, K0321, and K0923 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: K211 This standard is not met as evidenced by: Based on observation and interview, the provider failed to ensure one exit door and three exit access corridors were maintained free of obstructions which could impede egress during an emergency (e.g., a fire event). Findings include: 1. Observation on 7/15/25 at 11:30 a.m. revealed the laundry/maintenance exit access corridor contained a large variety of obstructions, including combustibles (items in cardboard	K 211	All corridors were cleared of obstructions & signage stating "non-storage areas" hung. Maintenance staff educated to keep areas clear of obstruction completed 8/4/25. Maintenance manager or designee will monitor corridors to ensure clear of obstruction weekly for a month, then monthly for 3 months. Results will be reported by maintenance manager or designee to the monthly QAPI meeting x 4 months or until the committee deems necessary.	8/30/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Erica Peterson*
TITLE: Administrator/CEO
(X6) DATE: 8/4/2025

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K 211	Continued From page 1 boxes). 2. Observation on 7/15/25 at 11:50 a.m. revealed the back hallway exit access corridor contained a variety of obstructions, including combustibles. 3. Observation on 7/15/25 at 12:25 p.m. revealed the exit door from the loading dock storage room was partially blocked by obstructions appearing to be refuse on the floor, including combustibles (items in cardboard boxes). 4. Observation on 7/15/25 at 12:30 p.m. revealed the exit access corridor between the hospital and dialysis center contained a variety of obstructions, including large furniture items which did not have flame spread ratings. Interview with the Finance Director and Maintenance Supervisor at the time of those observations confirmed those findings. This deficiency compromised one of ten building exit doors and three of seven exit access corridors.	K 211		
K 223	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect	K 223	Rope was removed, discarded plug was pulled from door and new door handle was installed. Laundry door strike was tightened allowing door to fully close. Completed 7/18/25. Maintenance staff educated to ensure all doors closed appropriately completed 8/4/25. Maintenance manager or designee will perform checks of all self-closing doors weekly for a month, then monthly for 3 months. Results will be reported by maintenance manager or designee to the monthly QAPI meeting x 4 months or until the committee deems necessary.	8/30/25

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K 223	Continued From page 2 smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: This standard is not met as evidenced by: Based on observation and interview, the provider failed to maintain two hazardous area enclosure doors. Findings include: 1. Observation on 7/15/25 at 10:50 a.m. revealed the door separating the boiler room, a hazardous area, from the mechanical/electrical room was held open by a rope tied between the doorknob and a conduit on the wall. The door was equipped with a closer. 2. Observation on 7/15/25 at 11:25 a.m. revealed the door separating the laundry room, a hazardous area, from the employee locker room did not self-close or latch. The door was equipped with a closer. Interview with the Finance Director and Maintenance Supervisor at the time of those observations confirmed those findings. These deficiencies compromised two of seven smoke compartments.	K 223		
K 321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing	K 321	All areas were sealed with fire caulk or fire foam to seal penetrations. Implemented a PM (Preventative Maintenance) checklist to continue to look for other penetrations and proper seal upon discovery. Maintenance staff educated on PM checklist for penetrations requiring immediate sealing completed 8/4/25.	8/30/25

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K 321	Continued From page 3 system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: This standard is not met as evidenced by: Based on observation and interview, the provider failed to maintain the smoke resistant partitions for four hazardous area enclosures. Findings include: 1. Observation on 7/15/25 at 11:20 a.m. revealed one approximately two-inch open pipe penetration through the ceiling of the boiler mechanical room for the instrument sanitizer. 2. Observation on 7/15/25 at 11:35 a.m. revealed four open spaces around approximately six-inch	K 321	Maintenance manager or designee will report PM results to the monthly QAPI meeting x 4 months or until the committee deems necessary.	

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K 321	Continued From page 4 pipe penetrations through the west wall of the maintenance shop. 3. Observation on 7/15/25 at 12:15 p.m. revealed six open spaces around pipe penetrations of various sizes through the north wall of the biohazard storage room. 4. Observation on 7/15/25 at 12:40 p.m. revealed three open spaces around pipe penetrations of various sizes through upper wall areas near the northwest corner of the long-term dialysis storage room. Interview with the Finance Director and Maintenance Supervisor at the time of those observations confirmed those findings. These deficiencies compromised three of seven smoke compartments.	K 321		
K 923	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.	K 923	Nitrous Oxide cylinder was moved to room where it is used and chained to the wall. The other cylinder, non-flammable nitrogen compressed, was left where stored and chained to the wall. Completed 7/16/25. Maintenance staff educated on proper storage room & chaining requirements on 8/4/25. Maintenance manager or designee will ensure that when a cylinder is exchanged, it is properly stored & chained in the correct area. Maintenance manager or designee will report proper storage & chaining results to monthly QAPI meeting x 4 months or until the committee deems necessary.	8/30/25

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K 923	Continued From page 5 Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: This standard is not met as evidenced by: Based on observation and interview, the provider failed to properly store oxidizing gases with a combined total volume of approximately 1,500 cubic feet. Findings include: 1. Observation on 7/15/25 at 12:00 p.m. revealed two S-size cylinders containing 65 pounds each of nitrous oxide, which were co-located with various other medical gases (e.g., nitrogen), and 18 E-size and 3 B-size cylinders containing oxygen which were in a rack approximately 20 feet away from the nitrous oxide and other gas cylinders. There were a number of combustibles located within five feet of both cylinder collections including cardboard, cloth blankets and towels,	K 923		

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K 923	Continued From page 6 plastics, and wooden furniture. Interview with the Finance Director and Maintenance Supervisor at the time of the observation confirmed the finding. This deficiency compromised one of seven smoke compartments.	K 923		

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	431329	A. BUILDING _____ B. WING _____	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN MEDICAL CENTER	300 S BYRON 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
E 000	Initial Comments A recertification health survey for compliance with 42 CFR Part 485, Subpart F, Subsection 485.625, Emergency Preparedness, requirements for Critical Access Hospitals, was conducted on 7/15/25. Sanford Chamberlain Medical Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Erica Peterson
TITLE: Administrator/CEO
(X6) DATE: 8/5/2025

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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	50302S	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CHAMBERLAIN MEDICAL 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted from 7/14/25 through 7/16/25. Sanford Chamberlain Medical Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Erica Peterson

TITLE
Adminstrator/CEO

(X6) DATE
8/5/2025