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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD CARE CENTER VERMILLION	125 S WALKER STREET , VERMILLION, South Dakota, 57069

(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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/30/25 through 10/2/25. Sanford Care Center Vermillion was found not in compliance with the following requirements: F677 and F812	F0000		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: Number of residents cited: Based on observation, interview, record review, and policy review the provider failed to ensure a formalized dining assistance program was conducted with identified family member of resident (18) who assisted resident 11 with dining. The provider also had no documentation of training for any other resident family members or visitors who offered dining assistance. Findings include: 1. Observation on 9/30/25 at 12:15 p.m. of in the dining room revealed: *A visitor used resident 18's utensils in her right hand and assisted him with eating. She then turned to her right and picked up resident 11's utensils with her right hand, and assisted resident 18 with eating. *The visitor did not wash her hands after she assisted resident 18 with eating before she assisted resident 11 with eating.	F0677	1. On 10/1/25, the MDS Coordinator educated the visitor who is Resident 18's wife that she can only assist her husband, Resident 18, at meals with feeding and no other residents. The MDS Coordinator educated this same visitor again on 10/16/25 at Resident 18's care conference that she is only able to assist him with feeding at meals and no other residents. Resident 18's wife verbalized understanding of this. All other residents have the potential to be affected. Through meal observation and interviews with staff, it has been determined that no other residents have been receiving assistance with meals from visitors other than their own family. 2. On 10/22/25, the Social Worker added to the admission agreement that if families come to meals, they can assist their family member with meals but not any other residents. The CEO emailed all the family contacts with the same information on 10/22/25 and the MDS Coordinator wrote an article for the family newsletter to include this same information. The newsletter will go out to all nursing home family contacts by 10/31/25. On 10/22/25, the Clinical Care Leader sent out an OnShift message to all licensed nursing staff to educate them that family members can't help other residents at meals; they can only help their own family member. On 10/21/25, the MDS Coordinator put out read and sign education for all licensed nursing staff with a copy of the policy on dining assistance for staff to read and sign off on. PRN staff will complete this before their next scheduled shift. 3. The MDS Coordinator or designee will observe 2 meals per week for one month, then 1 meal per week for one month, then 1 meal every other week for one month and one meal per month for 3 months to ensure visitors are not feeding other residents or assisting with meals, other than with their own family member. The MDS Coordinator or designee will report the results of the audits at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further 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	TITLE	(X6) DATE
Veronica Schmidt	CEO	10/23/2025

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F0677 SS = D	Continued from page 1 2. Interview on 9/30/25 at 12:30 p.m. with certified nursing assistant (CNA) C revealed: *She and a medication aid assisted residents with eating their meals. Resident 18's wife came in to the facility everyday to help her husband with eating, and would help other residents. *She stated resident 18's wife had not been trained to assist residents to eat but should have been. 3. Interview on 10/2/25 at 11:50 a.m. with resident 18's wife revealed: *She had not been trained regarding assisting resident with eating. She helped her husband and their friend with eating when she visited. She helped her husband and their friend with eating when she visited. She stated resident 11 could feed himself at times, but needed a little help from time to time. She helped her parents with eating in the nursing home years ago and at that time, she did not think she had to have training on assisting them. *She stated she should not have helped her friend with eating, and did not want to get anyone in trouble. *She would have called a nurse if anyone had a choking episode. *She confirmed she had used the same hand to feed both residents and stated, "I only touched the end of his fork." 4.Interview on 10/2/25 at 2:16 pm with Minimum Data Set (MDS) coordinator B revealed: *She did not have a list of visitors who were trained to provide feeding assistance to the residents. *She stated resident 18's wife had approached her yesterday and asked if she could be trained so she could assist her friend with eating. *She confirmed that resident 18's wife had not been trained on providing eating assistance. 5. Review of resident 11's electronic record (EMR) revealed:	F0677		

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F0677 SS = D	Continued from page 2 *He had impaired swallowing related to history of transient ischemic attack (TIA) (stoke) and dementia (a group of symptoms affecting memory), thinking and social abilities). *He used his left hand for eating due to a deformity of his right hand and used specialized silverware to accommodate that. *He had a Brief Interview for Mental Status (BIMS) assessment score of 12 which indicated his cognition was moderately impaired. 6. Interview on 10/2/25 at 3:01 p.m. director of nursing A regarding a visitor who assisted resident 11, who had impaired swallowing with eating revealed: *She was not aware that a visitor had assisted resident 11 with eating. *She expected anyone who had assisted a resident to eat would have been trained on how to safely provide that assistance but did not have a process for that training. 7. Review of Provider's 1/31/25 Dining Assistant policy revealed, "The location must ensure that a dining assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations and tube or parenteral/IV feedings. The resident selection must be based on the interdisciplinary team's assessment and the resident's latest assessment and plan of care.	F0677		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F0812		

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F0812 SS = E	Continued from page 3 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the provider failed to follow industry accepted food safety standards to ensure proper glove use by cook (E) while preparing and serving residents' food during one observed meal service according to the provider's policy. Findings include: 1. Observation on 9/30/25 at 11:40 a.m. of cook E while preparing residents' food in the dining room kitchenette revealed: *With her gloved hands she: -Touched the residents' menu slips. -Opened a bag of bread and pulled slices of bread out of the bread bag and placed them on top of the hot grill. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Opened the refrigerator door, removed a bag of sliced cheese, and placed it on the counter beside the hot grill. -Touched the bread slices on the hot grill and slid them around. -Opened the bag of cheese and placed cheese slices on those slices of bread. -Opened the refrigerator door and removed a zip lock bag of two precooked burger patties. -Placed those burger patties on a plate.	F0812	1. The Nutrition and Food Services Manager educated Cook E on proper hand hygiene and glove use while preparing and serving resident meals which included watching the video, "Gloves 101: Risk Nothing," the policy "Food Handling," and the policy "Hand washing and Glove Use for Nutrition Services" at the in-service meeting held on 10/23/25. Cook E will also complete the on-line education course, "Basics of Food Safety in Long Term Care Facilities" by 11/15/25. Most of the other Nutrition Services staff were educated at this same in-service on 10/23/25 with the same video and policies by the Nutrition and Food Services Manager. They will also complete the same on-line education course by 11/15/25. The staff that were unable to attend the in-service will complete read and sign education before their next shift and complete the on-line course by 11/15/25. PRN staff will complete the education before their next shift. All residents have the potential to be affected by this. 2. The Nutrition and Food Services Manager will review proper Hand Hygiene and Glove Use during meal preparation and serving quarterly at staff meetings and provide read and sign education for those unable to attend to sign off on before their next scheduled shift. The Nutrition and Food Services Manager will add to her monthly inspection a check of staff's proper use of gloves and hand hygiene during meal preparation and serving for ongoing sustainment of improvement. 3. The Nutrition and Food Services Manager or designee will audit 2 meals per week x 1 month, then 1 meal per week x 1 month, then 1 meal every other week x 1 month and then 1 meal per month for at least 3 months to ensure staff are using proper hand hygiene and glove use while preparing resident meals and serving. The Nutrition and Food Services Manager or designee will report the results of these audits at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

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F0812 SS = E	Continued from page 4 *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Removed a plate from a stack of clean plates and placed it on the counter by the hot grill. -Opened a bag of hamburger buns and removed two buns and placed them on plates. -Touched multiple resident menu slips. -Gathered a plate, bags of chips, and ketchup packets and placed them on the counter by the hot grill. -Touched both the grilled cheese sandwiches on the hot grill. -Touched the resident menu slips. -Removed frozen hamburger patties from the freezer and placed them on the hot grill. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Touched several resident menu slips. -Opened a bag of bread, removed 4 slices of bread from that bag and placed them on the hot grill. -Handled a bag of chips. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Handled a bag of chips. -Placed two slices of cheese on the bread slices on the hot grill. -Removed two hamburger buns from the plastic bag and placed them on plates. -Closed the bag of cheese and placed it back in the refrigerator. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Touched resident menu slips. -Maintained the grilled cheese sandwiches in place on the hot grill while she removed the edges with a spatula.	F0812		

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F0812 SS = E	Continued from page 5 -Gathered two plates from the stack of clean plates and placed them on the counter next to the hot grill. -Placed the grilled cheese sandwiches on the plates. *She then removed her gloves and washed her hands. *She gathered a plate from the stack of clean plates, flipped the hamburgers on the hot grill, and then removed a bag of sliced cheese from the refrigerator. *She put on a new pair of gloves. With those gloved hands she: -Removed two slices of cheese from the bag and placed them on the hamburgers on the hot grill. -Placed the hamburger buns on top of the bag of cheese. -Gathered plates from the stack of clean plates and plated the hamburgers. *She removed her gloves and served the plated to the residents. Interview on 9/30/25 at 12:30pm with cook E revealed: *She thought she made a mistake when handing the residents' food items with her gloved hands but was unsure. *She felt her process of making the food was "bad" because she had to make multiple trips to the sink to wash her hands and put on new gloves. *She agreed that she should not have touched non-food items with her gloved hands and then touch the residents' food. Interview with dietary manager D immediately following the above interview with cook E revealed: *She had been worried about the staff's glove use practices in the kitchen. *Some staff chose to wear gloves in the kitchen while preparing and serving the residents' food but did not follow the best process. *She was aware cook E wore gloves and touched other items before touching the residents' food.	F0812		

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F0812 SS = E	Continued from page 6 *She expected staff to use proper glove use while preparing and serving residents' food. Review of the provider's revised 2/9/25 Sanitary Service of Food policy revealed: *"To prevent foodborne illness by preventing cross-contamination of foods during service." *"All foods will be served in a manner that reduces possible chemical, physical, or biological contamination." *"Use proper hand washing procedures to wash hands and exposed arms up to elbows prior to handling or serving any food." *"Do not use bare hands to directly touch or handle any foods during food preparation or service. Gloves are to be worn to handle any food with bare hand contact when prepping food, preparing a recipe, or serving food. Gloves are not worn when using utensils to mix or serve foods." *"Wash hands before putting on gloves, each time gloves must be changed, when changing tasks, before beginning to serve food with utensils." *"Handle plates by the edge or rim, cups by the bottom or handle, and utensils by the handles only."	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

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K0000	INITIAL COMMENTS A recertification survey was conducted on 10/1/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Sanford Care Center Vermilion was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000		
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire	K0363	1. On 10/1/25, the Maintenance Supervisor removed the over-the-door wreath holder from Room 107's door. On 10/22/25, Maintenance Staff and the Director of Nursing surveyed all of the doors at the nursing home to ensure there were no other over-the-door hangers or other items on the doors that prevented them from closing and latching shut. 2. On 10/22/25, the Social Worker added to the nursing home admission agreement the following information to the list of items not to bring to the nursing home: no over-the-door wreath hangers or other similar items that would prevent the resident's door from closing and latching shut. The CEO also emailed all family contacts with the same information on 10/22/25 and the MDS Coordinator wrote an article for the November family newsletter to include this same information which will go out to all nursing home family contacts by 10/31/25. 3. Maintenance staff will include a check for over-the-door hangers and ensure doors close and latch shut when completing nursing home environmental rounds. These will be done monthly at the nursing home for a period of 6 months and then will be done at least quarterly. Any variances found will be taken care of at that time and reported to the Director of Nursing for follow up with resident/family. The Director of Nursing or designee will report the results of the monthly environmental rounds at the monthly QAPI meeting beginning on 11/19/25 until the facility demonstrates sustained compliance as determined by the committee.	11/16/25

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Veronica Schmidt	CEO	10/23/2025

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K0363 SS = D Bldg. 01	Continued from page 1 resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to ensure no impediment to the closing of one randomly observed corridor door (room 107) with an over the door wreath holder. Findings include: 1. Observation and testing on 10/1/25 at 2:20 p.m. revealed the corridor door to room 107 would strike and wedge the over-the-door wreath holder hung from the top of the door. That wreath holder prevented the door from closing and latching. Corridor doors are required to close and latch in order to resist the passage of smoke. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. He removed that over-the-door wreath holder at that same time to return the door to its correct operation.	K0363		

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E0000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted on 10/1/25. Sanford Care Center Vermilion was found in compliance.	E0000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Veronica Schmidt	CEO	10/23/2025

South Dakota Department of Health

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	10697	A. BUILDING: _____ B. WING _____	10/02/2025

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S 000	Compliance/noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/30/25 through 10/2/25. Sanford Care Center Vermillion was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Veronica Schmidt

TITLE
CEO

(X6) DATE
10/23/25