STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3)DATESURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	C 07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREETADDRESS, 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 recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/8/24 through 7/11/24. Sanford Chamberlain Care Center was found not in compliance with the following requirement: F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 7/11/24. Areas surveyed included resident safety related to a resident who eloped (left the facility without staff knowledge) and an open area on a resident's buttock. Sanford Chamberlain Care Center was found not in compliance with the following regulations: F609, 658, and F689.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s):483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609	Elopement education including the care planning process of updating, adjustments and implementation of interventions for those residents with a history of elopement. All residents with a history of elopement will have their care plans reviewed and revised if needed. Education completed at all staff meeting on 7/25/24. One to one education to those not present will be completed by 8/3/24. Review of care plans for residents with a history of elopement will be monitored weekly x 4 weeks, then monthly x 6 months by DON or designee. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary. Elopement drills to ensure adherence to policy will be done weekly x 4 weeks, then monthly x 6 months by the DON or designee. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary. All safety events will be reviewed for timely reporting daily x 1 month, then 5 events monthly x 6 months by the DON or designee. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary.	8/3/24

OR PROVIDER/SUPPLIER/CLIA REPRESE

Administrator/CEO

8/1/24

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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F 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, observation, interview, and policy review, the provider failed to ensure the South Dakota Department of Health (SD DOH) had been notified of two of three incidents of elopement for one of one sampled resident (24). Findings include: 1. Review of resident 24's medical record revealed: *He was admitted on 11/11/21. *His diagnoses included dementia with behavioral disturbances and Alzheimer's disease. *His Brief Interview of Mental Status (BIMS) score was a 99, which indicated the interview was not successfully completed. *He had eloped from the facility on 3/1/24, 3/24/24, and 7/10/24. *On 3/1/24 a nurse's progress note indicated: -"resident was found outside the Hamilton West end door." -"Two certified nursing assistants (CNAs) were putting residents to bed and stated they did not see resident leave the building." -"[Another resident] was yelling out that the	F 609		

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F 609	Continued From page 2 resident [24] had gone out of the North end door on Mueller household and the door alarm was going off." -"Resident was brought into the West end Hamilton door and walked to the Mueller household. Wander guard [Wander Guard] [a bracelet door alarm device] remains in place on residents left wrist and is working." *On 3/24/24 a nurse's progress note indicated: -"Front door alarm of the Care Center was alarming. This nurse went to investigate and found that resident went through the double doors and was walking but not yet made it to the parking lot. He was easily re-directed back into facility. Resident has a birthday today and seems a little anxious." Interview and record review on 7/11/24 at 2:35 p.m. with director of nursing (DON) B and director of nursing trainer (DON) M regarding resident 24 revealed: *DONT M indicated he had eloped once, "in the last year". -He had pushed open the door and walked out. *On 3/1/24 a resident had alerted staff that he had exited the building. -DONT M had not considered this an elopement as it was "witnessed" by another resident. *On 3/24/24 he had walked out the front double doors onto the sidewalk. -DONT M had not considered this an elopement as he had not made it "into the parking lot". -DON B indicated he had no knowledge of resident 24's elopements on 3/1/24 and 3/24/24. *On 7/10/24 resident 24 had eloped again. *After review of resident 24's nurse's progress notes from 3/1/24 and 3/24/24, DONT M confirmed those incidents had been elopements and should have been reported to the SD DOH.	F 609		

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F 609	Continued From page 3 Review of the provider's 7/10/24 Security Alert: Missing Person-Elopement policy revealed: *"Upon return of the resident to the facility, the following steps will be carried out: -An incident report will be completed. -The person responsible for the resident's care shall initiate an appropriate plan of treatment. -The resident's care plan will be revised to reflect elopement and prevention plan developed." -"Elopement assessment will be completed." -"Care planning team will meet each week and as needed to investigate any elopements to ensure safety of all residents and to prevent any elopement from reoccurring."	F 609		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (24) identified at risk for developing skin injuries and who had acquired a skin injury (wound) received: *Timely skin assessments performed by professional licensed staff. *Timely notification to his physician to obtain orders for treatment. Findings include: 1. Observation and interview on 7/11/24 at 4:20 p.m. with nursing supervisor and wound care	F 658	Weekly skin assessments assigned in TAR (Treatment Assessment Record) on 7/24/24. CNA will report skin assessment concerns to the nurse by the end of their shift. Nurse will complete skin assessment the day of notification. Change of process: Education completed at All Staff Meeting on 7/27/24. One on one education to those nurses not present will be completed by 8/3/24. Skin Assessments will be monitored for completion with 10 charts per week for 4 weeks and then 10 charts monthly x 6 months by DON or designee. Results will be reported to the monthly QAPI meeting x 6 months or until committee deems necessary.	8/3/24

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F 658	Continued From page 4 nurse (NS/WCN) H regarding resident 24's wound revealed: *He was in his room sitting in his recliner watching television. *When asked to observe his wound he gave his permission and was able to reposition, stand, ambulate and reposition his pants independently. *He had an approximate 1.3 centimeter (cm) length by 0.2 cm width by .02 cm deep open wound with a skin flap near the center left inner buttocks. *The wound was clean, and had no drainage. *NS/WCN H stated the wound had been deeper but was healing from the inside out. *He was prone to and had a history of boils to that same area. *The wound was being treated with Mepilex (an absorbent foam dressing). *NS/WCN H had been asked to look at the wound on 6/26/24 at the end of the day by the staff nurse who had worked that evening shift. *The wound had been assessed by physical therapy and determined the cause of the wound was not related to pressure. Review of resident 24's medical record revealed: *He was admitted on 11/11/21. *His diagnoses included dementia with behavioral disturbances and Alzheimer's disease. *His Brief Interview of Mental Status (BIMS) score was a 99, which indicated the interview was not successfully completed. *His 7/11/24 care plan had a focus initiated on 7/28/22 that indicated he had impaired skin related to redness of abdominal folds and/or his groin and was receiving treatment. -The interventions for this focus included: --"Conduct a systematic skin inspection every week with baths & [and] PRN [as needed]." --"Monitor and record any complaints of	F 658		

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F 658	Continued From page 5 pain/itching/discomfort (location, durations, quantity, quality, alleviating factors, aggravating factors)." –"Administer medications/treatments as ordered, obtain lab/diagnostics as ordered, monitor for improvement." *His July 2024 treatment administration record revealed an order initiated on 6/27/24 that indicated he had an open wound to his left buttock. -On 7/2/24 a physician order for "Mepilex and Medihoney [wound healing product] to left buttock every 3 days and PRN". Review of the "C.N.A. [certified nursing assistant] SKIN INSPECTION REPORT" form for resident 24 revealed a licensed nurse had dated and signed each form and the forms: *Identified on 6/17/24 a "sore" on his right buttock. *On 6/19/24 there were no skin impairments identified. *Identified on 6/21/24 "redness" to his groin area and "swollen" on both lower legs. *Identified on 6/24/24 a "sore" was identified on his left buttock. *On 6/26/24 there were no skin impairments identified. *Identified on 6/28/24 an "open sore" to his left buttock. Interview on 7/11/24 at 3:00 p.m. with director of nursing (DON) B regarding resident 24's buttock wound revealed: *On 6/26/24 at approximately 5:00 p.m. WCN/RN H had assessed resident 24's buttocks, found a wound on the left side of his buttock, and she had placed Mepilex on it. -She had not notified his primary care provider or	F 658		

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F 658	Continued From page 6 his family at that time. *On 6/27/24 DON B and NS/WCN H had assessed resident 24's left buttock and they were unable to determine the type of wound it was. -His primary care provider was notified of the wound, and he ordered Mepilex dressing and a physical therapy evaluation. *On 7/2/24 the physical therapist evaluated the wound and indicated it was an abrasion and it "doesn't look like pressure ulcer. has hole punch look and some skin build up on the medial [near the center left inner buttock] side of it (skin tag like)." Interview on 7/11/24 at 4:10 p.m. with NS/WCN H, DON B, and DONT M regarding resident 24's C.N.A. Skin Inspection Reports revealed: *NS/WCN H indicated the 6/17/24 report had "probably the wrong side of butt", it had indicated the right side of his buttocks and she had identified it on the left side of his buttocks. *She thought a CNA was able to identify skin concerns, complete the CNA Skin Inspection Report, and provide the completed form to the nurse for follow-up. Interview on 7/11/24 at 5:24 p.m. with NS/WCN H and DONT M regarding resident 24's wound revealed: *He may have had a different skin wound prior to his current wound on his left buttock. -He would have been kept on a skin monitoring schedule for two weeks for any wounds. -DONT M was not able to confirm if he had been on a monitoring schedule prior to 6/26/24. Interview on 7/11/24 at 5:32 p.m. with NS/WCN H regarding resident 24's wound revealed: *On 6/26/24 a charge nurse on duty had told her	F 658		

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F 658	Continued From page 7 to look at the wound on his buttocks. *The 6/26/24 C.N.A. Skin Inspection Report had been completed by another nurse after NS/WCN H had assessed his wound. -That assessment indicated there were no skin concerns. -A nurse had signed that assessment. -The nurse's signature indicated they had acknowledge of what the CNA reported on the form. -Above the nurse's signature was a place to write any new interventions they had implemented. *When a resident had a bath, the CNA would have documented any skin concerns on the CNA skin inspection report. *Nurses were to have completed a weekly skin assessment. -When an assessment was completed by a nurse, it would have been documented in the nurse's progress notes. *When a resident was identified with a wound, a progress note "Event" was made and each week an additional progress note that indicated the status of the wound was attached to that initial "Event". *A formal skin assessment was completed by a nurse when a resident was admitted, then quarterly, and annually. Continued interview on 7/11/24 at 6:00 p.m. with NS/WCN H regarding wound assessments revealed resident 24 was not on the nurse's weekly assessment schedule. *She confirmed no weekly nurse skin assessment had not been completed by a nurse on a routine basis for resident 24. Review of the provider's nursing assistant job description revealed:	F 658		

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F 658	Continued From page 8 *"Communicates resident's changing condition and care related concerns/responses to the charge nurse." *It does not include assessing the condition of a resident's skin. Review of the provider's 7/10/24 Skin Breakdown Prevention (Pressure Ulcers) policy revealed: *"The following principles have been adopted and are to be included in skin care and early treatment:" -"Any deviation in skin assessment shall be noted and documented in the patient/resident's clinical record." A policy for assessing a resident's skin was requested on 7/11/24 and was not received by the end of the survey.	F 658		
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), observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (24) who eloped (left the facility without staff knowledge) and while he was outside of the building, fell and required	F 689	Programming pagers to be worn by staff will alert when doors are alarmed. (Date of completion 8/3/24). Education on alert pagers will be completed by 8/3/24 Elopement drills to ensure adherence to policy will be done weekly x 4 weeks, then monthly x 6 months by the DON or designee. Results will be reported to the monthly QAPI meeting x 6 month or until the committee deems necessary. Wander Guards will be tested monthly and reported by DON or designee. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary.	8/3/24 8/3/24

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F 689	Continued From page 9 evaluation at the emergency department. Findings include: 1. Review of the SD DOH FRI revealed: *On 7/10/24 resident 24 had walked out the front double doors of the building without staff knowledge. 2. Observation on 7/11/24 at 11:16 a.m. of resident 24 in his room revealed: *He had small scabbed-over lacerations to the top of his nose, and his upper and lower lip. *He was smiling, laughing, pleasant, cooperative, and conversive with intermittent garbled and nonsensical speech. 3. Interview on 7/11/24 at 11:27 a.m. with registered nurse (RN) J revealed: *RN J had worked as a permanent staff member for five months and had not worked the previous evening when resident 24 eloped. *Resident 24 moved into the facility a year ago, was ambulatory, and did not use any assistive devices to ambulate. *Residents were assessed for risk of elopement on admission and when newly identified as at risk for elopment. *The social worker was notified when residents were identified as at risk for elopement and obtained orders for a Wander Guard (bracelet door alarm device). *Resident 24 wore a Wander Guard wristwatch, was never known to take his Wander Guard off, had gotten out of the facility the evening prior, and had a history of eloping in the past. *Staff monitored resident 24 closely, but there were no set times or frequencies for rounds (staff checks of resident status and care needs) or documentation of rounds.	F 689		

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F 689	Continued From page 10 *Staff communicated at shift change report and he felt the certified nursing assistants (CNAs) were "good at reporting" to the nurse if residents were observed to have had increased wandering or risk of elopement behaviors. *The Wander Guard was resident 24's primary intervention for his risk of elopement. 4. Interview on 7/11/24 at 11:39 a.m. with CNA K revealed: *She had worked as a permanent staff member for one year and had not worked the previous evening when resident 24 eloped. *She had heard that resident 24 had gone out of the front door, tripped, fell, hit his nose, and was taken to the emergency department. *The resident had a Wander Guard watch, and no residents removed their Wander Guards that she was aware of. *They monitored residents closely, approximately every thirty minutes, when they went up and down the hallways but there were no set times or frequencies or documenting of that. *Staff communicated at shift change report, and in a communication book at the nurse's station. The CNAs reported to the nurse if residents were observed to have had increased wandering or risk of elopement behaviors. 5. Review of resident 24's medical record revealed: *He was admitted on 11/11/21. *His diagnoses included dementia with behavioral disturbances and Alzheimer's disease. *His Brief Interview of Mental Status (BIMS) score was a 99, which indicated the interview was not successfully completed. *He had eloped from the facility on 7/10/24. *A 7/10/24 a nurse's progress note indicated:	F 689		

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F 689	Continued From page 11 -"Noted by activities coordinator that a passerby said someone was lying facedown on the concrete outside the building. CNA staff ran out there and found resident. As I was getting to the resident I could see blood coming from his mouth and nose. He appears to have cut his bottom lip and has a small laceration to the top of his nose. Resident was able to roll with assistance to his side and was sat up right. He was then assisted up and into a wheelchair. The bleeding is minimal. In examining the resident his nose appeared to be misshapen." -"Decision made to send to ED [emergency department] for evaluation of this." -On 7/10/24 a follow-up nurse's progress note indicated: --"Resident has returned from ED and ruled out fracture or acute head injury." --"Of note, it was determined residents fall was witnessed, by the time the CNA's were getting to him to assist him back to the building, he fell then." 6. Review of resident 24's 7/11/24 care plan revealed: *An initiated focus on 11/16/21, and revised on 4/11/24, that he experienced wandering due to his dementia, wandered without a destination or any safety awareness, and had a WanderGuard on his left wrist. -The goal for this focus was that he would wander safely within the specified boundaries. --There were no boundaries specified. -The interventions for this goal included: --"Equip resident with a wander guard [WanderGuard] device that alarms when wanders, apply to left wrist. Check for proper functioning of device every night and skin breakdown."	F 689		

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(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 12 --"Avoid over-stimulation (e.g., noise, crowding, other physically aggressive residents). --"Maintain a calm environment and approach to [resident 24]. --"Remove [resident 24] from other resident's rooms and unsafe situations." 7. Review of resident 24's July 2024 treatment administration record revealed: *A 1/4/24 order to monitor for "Wander guard [WanderGuard] on at all times (left wrist) with daily activation check at night." *The diagnosis for this treatment was "Unspecified dementia with behavioral disturbance". 8. Review of resident 24's 7/10/24 Elopement Risk assessment revealed: *He had wandered in the past 60 days. *His diagnoses included dementia and Alzheimer's disease. *Contributing factors to this elopement were "Repeatedly Opening Doors/Setting Off Alarms of Secured Doors" and "Wandering With No Rational Purposes And Attempting To Open Doors". 9. Interview on 7/11/24 at 2:35 p.m. with director of nursing (DON) B and director of nursing trainer (DONT) M regarding resident 24 revealed: *On 3/1/24 a different resident had alerted staff that resident 24 had exited the building. *On 3/24/24 resident 24 had walked out of the front double doors onto the sidewalk. *On 7/10/24 resident 24 had walked out of the front double doors onto the sidewalk. -He had tripped and fallen while coming back into the building.	F 689		

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	43A073	A. BUILDING _____ B. WING _____	C 07/11/2024

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F 689	Continued From page 13 10. Interview and review of a video recording on 7/11/24 at 3:40 p.m. with DON B and director of finance N revealed: *At 7:36 p.m. resident 24 held one side of the front double doors for 12 seconds until it opened and walked through the door and exited the building. *At 7:37 p.m. a staff member exited the bathroom in that area, looked through the front double doors, shut off the alarm, and walked around the corner to a different hallway. *At 7:38 p.m. two CNAs ran from the way the staff member above had gone to the front double doors and exited the building. *At 7:40 p.m. a nurse went to the front double doors and exited the building. *At 7:43 p.m. that same nurse returned inside while she talked on her cellphone. *At 7:44 p.m. that same nurse and another CNA exited the building through the front double doors. *At 7:46 p.m. that same nurse, and three CNAs returned with resident 24, seated in a wheelchair back inside the building. 11. Interview on 7/11/24 at 4:10 p.m. with nursing supervisor/wound care nurse (NS/WCN) H, DON B and DONT M regarding resident 24's elopement revealed: *Interventions in place for his elopements included staff were to monitor him during "normal rounding every two hours" and a Wander Guard was placed on his wrist. -They indicated there were no other interventions in place to prevent him from elopement. 12. Review of the provider's 7/10/24 Security Alert: Missing Person-Elopement policy revealed: *"Upon return of the resident to the facility, the following steps will be carried out:	F 689		

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F 689	Continued From page 14 -An incident report will be completed. -The person responsible for the resident's care shall initiate an appropriate plan of treatment. -The resident's care plan will be revised to reflect elopement and prevention plan developed." -"Elopement assessment will be completed." -"Care planning team will meet each week and as needed to investigate any elopements to ensure safety of all residents and to prevent any elopement from reoccurring."	F 689		
F 812 SS=F	FoodProcurement,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. (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, record review, and policy review, the provider failed to ensure necessary food safety guidelines were followed for two of two kitchenettes located in the 100 and	F 812	LTC kitchens and appliances were deep cleaned on 7/16/24. All food in storage, refrigerators and freezers were labeled appropriately with opened and expiration dates. Disposable Teflon oven liners are placed in each oven. The daily/monthly dietary aides' checklist will be reviewed and/or revised to ensure the dating of opened food items and deep cleaning of the kitchenettes is included. Education on cleaning and appropriate labeling completed with dietary staff on 7/18/24. Environmental rounding to include monitoring of cleanliness of appliances and kitchenettes and dating of stored open food will occur daily x 4 weeks, then 2 times a week x 6 months by dietary manager or designee. Results will be reported to the monthly QAPI meeting x 6 months or until the committee deems necessary.	8/3/24

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F 812	Continued From page 15 200 hallways which included: *The appropriate storage and labeling of food items. *The cleaning and safe maintenance of kitchen surfaces and appliances. Findings include: 1. Observation on 7/8/24 at 5:32 p.m. of the 200-hallway open-concept kitchenette revealed: *The exterior of the refrigerator had a build-up of dried grayish colored sticky material on and around the door handle. *The interior of the refrigerator contained multiple food items that were opened and not dated or labeled including: -One half-can of vanilla frosting with no opened date. -One partially empty package of blueberry bagels with no opened date. -Two plastic cling-wrapped packages of sliced cheeses with no identifying labels or opened dates. -Two large plastic squeeze bottles of salad dressing substances with no identifying labels or opened dates. -One half-empty bottle of barbeque sauce with no opened date. -One partially empty bottle of cocktail sauce with no opened date. -One partially empty container of parmesan cheese with no opened date. *All the refrigerator shelves and pull-out drawers contained multiple scattered un-identified dried food particles and food stains. *The bottom pull-out freezer contained: -Multiple clear plastic wrapped packages of pre-cooked pancakes that had no identifying labels or expiration dates. -Laying on top of those pancakes was a large,	F 812		

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F 812	Continued From page 16 partially used, unsealed plastic package of unlabeled and undated exposed microwave bacon. *The water dispenser and ice machine had a buildup of splattered dried lime scale on the exterior surface and a yellow colored slime layer in the catch tray. The machine was dripping water. The water supply lines were coated with a dried, white scaly substance. *The following items were under the kitchen sink next to the dishwasher: -Two one-gallon jugs of "Spar-Chlor" chlorinated dish sanitizer. One of those jugs had a plastic tube inserted into an unsealed lid which led to the dishwasher. The plastic tube had a dried, unidentified, white substance buildup extending the length of the tube. -Two half-empty gallon jugs of "Detergent II Sanitizing dish cleaner." -One half-empty gallon jug of pot and pan detergent. -Four various brands of spray-on kitchen surface cleaner. -One can of spray-on oven cleaner. -The bottom shelf was soiled with spilled cleaning supplies. *The toaster had dried breadcrumbs around and under the toaster. *The exterior of the microwave was sticky to the touch with multiple splatters of unidentified substances. *The surfaces of the flat-top stove and oven had multiple dried grease-type splatters. The oven's glass door was difficult to see through due to the amount of burnt particles. The inside of the oven had burnt-on dried food residue on the bottom shelf. *Multiple clean utensil drawers had drawer handles that were sticky to the touch and dried	F 812		

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F 812	Continued From page 17 food particles were located underneath the clean utensils. Interview on 7/9/24 at 10:01 a.m. with environmental services supervisor (EVS) D regarding kitchenette cleanliness and maintenance revealed: *The EVS staff were responsible for the cleaning of the floors in the kitchenette. *The dietary department and dietary aides were responsible for all other cleaning and maintenance of the kitchenettes. -The dietary department and dietary aides were employed by the adjacent hospital. *He stated the hospital's dietary department were responsible all other cleaning and maintenance of the ice and water machines. Observation on 7/10/24 at 9:26 a.m. of the 200-hallway kitchenette revealed the above mentioned items remained unchanged. The refrigerator then contained another opened, undated gallon of milk, and opened, undated, packages of grapes and oranges. Interview and observation of the 200-hallway kitchenette on 7/11/24 at 9:47 a.m. with director of nursing (DON) B revealed: *He stated all food items were supplied by the hospital and the hospital's dietary department aides should have cleaned the kitchenettes and ensured the opened food items were labeled and dated. *He was not aware of the cleaning chemicals located under the kitchenette's sink and agreed they should not be within easy access of the residents. *He confirmed the kitchenette and food supplies were not maintained in a clean, safe manner and	F 812		

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F 812	Continued From page 18 many opened food items were not labeled or dated with an opened date. Interview on 7/11/24 at 11:14 a.m. with infection control (IC) nurse L regarding the condition of the kitchenettes and the undated, unlabeled opened food items revealed: *She was the IC nurse for both the hospital and the nursing home. *She was not aware of the condition of the kitchenettes and had not audited the kitchenettes for IC standards. -She stated every department was responsible for auditing their department and reporting the results during quality assurance meetings. *She agreed that poor cleaning methods and unlabeled and undated perishable food items could place the residents at an increased risk for food born illnesses. -She stated there had not been any food born illnesses that she was aware of. 2. Observation on 7/8/24 at 5:40 p.m. in the 100-hallway open-concept kitchenette revealed: *The interior of the refrigerator contained multiple food items that were opened and not dated or labeled including: -Celery, strawberries, blueberries, grapes, cheese slices, various syrups, milk and a wilted cucumber. -A container of 2 slices of bologna dated 5/20/24. -An opened container of apple butter that had the name "{Resident Name}" on it dated 4/26. *The bottom pull-out freezer contained: -Dirt and unidentified dried food particles on the top portion of the freezer door. -One opened bag of sausage links that had 2 links left.	F 812		

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F 812	Continued From page 19 -One opened package of unidentified food. -One package of bacon with "packaged on 4/25/24 written on it". Observation on 7/9/24 at 8:38 a.m. in the 100-hallway kitchenette revealed: *The coffee machine, microwave, toaster, and dishwasher were unclean. *There were multiple cleaning supplies located under the sink including: -Two one-gallon jugs of "Spar-Chlor" chlorinated dish sanitizer. One of thoe jugs had a tube inserted into it that led to the dishwasher. -Two one-gallon jugs of "Detergent II Sanitizing dish cleaner." One of the jugs had a tube inserted into it that led to the dishwasher. -One gallon jug of Bleach. -Two different types of spray-on kitchen cleaners. Interview on 7/11/24 at 8:52 a.m. with cook I revealed: *He had been employed with the facility since 2021. *He had cleaned, washed, and wiped down the kitchen daily. *One-time a week he had been going through the fridge and labeling and discarding food. *All the cooks and dietary aides were responsible to have kept the kitchenette, refrigerator and freezer clean and to have labeled all of the food items with the opened date. *He agreed there were food items that were not labeled and food items that should have been thrown out. Interview on 7/11/24 at 9:35 a.m. with nutrition and food services supervisor E revealed: *She had been employed with the facility since 2011.	F 812		

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F 812	Continued From page 20 *She had been checking the kitchenettes on the 100 and 200 halls two times a week. -She checked if the temperatures on the refrigerators and freezers were taken, the pantry was stocked, and the ovens were cleaned by the cooks and dietary aides. *The cooks and the dietary aides had a checklist to mark off the cleaning of the kitchenettes for weeks and monthly checkoffs which included outdated of food. -She would review the checklist and discuss with the team if they were not filled out and why. *She would have expedted staff to clean kitchenettes, date and label the food when opened, throw away food when it expired complete the cheklist and stock the pantry. *She agreed the kitchenettes needed to be cleaned, the foods in the refrigerators had not been labeled and there were food items that needed to be thrown out. Review of the provider's April through July 2024 "Care Center Household Cleaning Weekly and Monthly Kitchen and Dining Room" cleaning checklists for the 100 and 200 hallways' kitchenettes revealed there were multiple weekly and monthly cleaning checklist items that had not been initialed as completed by dietary staff. Review of the provider's 6/11/23 Equipment Cleaning, Sanitizing and Cleaning Surfaces policy revealed: *"All equipment and work surfaces will be sanitized in accordance with standards as set by the State Health and Sanitation Department." *"All equipment used and work surfaces will be cleaned and sanitized daily." Review of the provider's 1/24/23 HACCP Leftover	F 812		

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F 812	Continued From page 21 Foods policy revealed: *"Potentially hazardous food items must be handled in regulation compliance." *"All stored leftover food[s] are covered, labeled, and dated. They are stored in reusable containers." *The policy had not included instruction on when to discard expired food items.	F 812		

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E 000	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 7/11/24. Sanford Chamberlain Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator/CEO | (X6) DATE: 7/30/24

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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	43A073	A. BUILDING **02 - BUILDING 2 REPLACEMENT BLDG** B. WING _____	**07/11/2024**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/11/24. Sanford Chamberlain Care Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K353, K363, K712, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 363 SS=B	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	K 363	Door was removed and trimmed with ¾" clearance then hinge replaced 7/12/24. All doors checked for proper closure have been added to PM for Maintenance. Audit for proper closure of all doors will occur weekly x 1 month, then monthly x 6 months by Maintenance or designee. Results will be reported to the monthly QAPI meeting x 3 months or until the committee deems necessary.	7/12/24

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

TITLE: Administrator/CEO

(X6) DATE: 7/30/24

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K 363	Continued From page 1 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 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 REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain impediment free closing for two randomly observed corridor doors (room 119 and the salon) as required. Findings include: 1. Observation on 7/11/24 at 8:40 a.m. revealed the corridor door to room 119 would drag on the floor and would need to be lifted to ensure the door would close and latch. Interview with the plant operation supervisor revealed the floor would heave in warm weather and create an impediment to the door closing. 2. Observation on 7/11/24 at 2:45 p.m. revealed the corridor door to the salon would drag on the floor and would need to be lifted to ensure the door would close and latch. Interview with the plant operation supervisor revealed the floor would heave in warm weather and create an impediment to the door closing.	K 363		

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SANFORD CHAMBERLAIN CARE CENTER	**300 S BYRON BLVD CHAMBERLAIN, SD 57325**

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K 363	Continued From page 2 Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. He said the hinge screws could be tightened to alleviate the condition. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to: *Maintain documentation of fire drills for the calendar year 2024 for both 2:00 p.m. to - 10:00 p.m. and 10:00 p.m. to - 6:00 a.m. shifts. *Hold fire drills in the first quarter of 2024 (January, February, and March) on the second and third shifts. *Hold fire drills at varying times during the first shift, 6:00 a.m. to 2:00 p.m. Findings include: 1. Record review on 7/11/24 at 10:20 a.m.	K 712	Fire drill audit sheet was revised to include proper times for shifts for each quarter. Fire drill sheet will be audited by the 15th of each month to ensure all shifts are included x 6 months by Maintenance or designee. Results will be reported to the monthly QAPI meeting x 3 months or until the committee deems necessary	7/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING **02 - BUILDING 2 REPLACEMENT BLDG** B. WING _____	**07/11/2024**

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K 712	Continued From page 3 revealed the provider had three shifts. Documentation of fire drills for the calendar year 2024 was as follows: First 6:00 a.m. to 2:00 p.m. Shift Second 2:00 p.m. to 10:00 p.m. Shift Third 10:00 p.m. to 6:00 a.m. Shift 1/26/24 9:57 a.m. 2/19/24 10:56 a.m. 3/25/24 9:29 a.m. 4/29/24 10:23 a.m. 5/6/24 00:15 a.m. 6/24/24 9:40 a.m. The documentation lacked second and third shift fire drills for January, February, and March 2024. The documented timing of the first shift fire drills also did not indicate varied times for holding fire drills as required for the training of staff. Interview with the plant operations supervisor at the time of the record reviews confirmed those findings.. The deficiency had the potential to affect 100% of the building occupants.	K 712		
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches.	K 918	Load back test completed on 7/27/24 was short of 30%. On 8/1/24 3E will be doing a load back test. Audit to review weekly 30% test documentation to ensure completion will occur weekly x 1 month then monthly x 6 months by Maintenance or designee. Results will be reported to the monthly QAPI meeting x 3 months or until the committee deems necessary	8/1/24

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	43A073	A. BUILDING **02 - BUILDING 2 REPLACEMENT BLDG** B. WING _____	07/11/2024

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K 918	Continued From page 4 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to perform generator maintenance as required (load bank testing) for the Kohler 250 kW diesel generator for 2023. Findings include: 1. Record review on 7/11/24 at 10:00 a.m. revealed there was no documentation the monthly load runs met or exceeded thirty percent (30%) of the Kohler 250 kW generator's name plate capacity to avoid an annual load bank test for a diesel generator. Documentation showed a	K 918		

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	43A073	A. BUILDING **02 - BUILDING 2 REPLACEMENT BLDG** B. WING _____	07/11/2024

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K 918	Continued From page 5 load bank had been performed on 11/2/22. Interview with the plant operations supervisor at the time of the record review confirmed that finding. He added he was unsure if the monthly generator load runs met or exceeded the 30% requirement. The deficiency affected one of numerous generator maintenance requirements.	K 918		

South Dakota Department of Health

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	10606	A. BUILDING: _____ B. WING _____	C 07/11/2024

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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 7/8/24 through 7/11/24. Sanford Chamberlain Care Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/8/24 through 7/11/24. Sanford Chamberlain Care Center was found in compliance.	S 000		

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

TITLE: Administrator/CEO

(X6) DATE: 7/30/24

RECEIVED
JUL 30 2024
SD DOH-OLC