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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	03/25/2021

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

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F 000	INITIAL COMMENTS Surveyor: 41088 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/23/21 through 3/25/21. Sanford Chamberlain Care Center was found not in compliance with the following requirements: F880 and F812. On 3/23/21 at 6:15 p.m., an immediate jeopardy was identified with infection control at F880. On 3/23/21 at 9:10 p.m. senior director A provided a removal plan per email. The removal plan was accepted on 3/24/21 at 5:27 p.m. with agreed upon changes made by the provider while the surveyors verified the plan and the Immediate Jeopardy was removed on 3/24/21 at 5:30 p.m. The resident census was 41.	F 000		
F 812 SS=D	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. (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.	F 812	Nutrition and Food Service Dress Attire policy updated on 3/29/21. Update includes hair restraints must be worn at all time in the nutrition services department. Education provided during food service training on 4/1/21. Education dually signed by staff member and witness prior to the start of their next shift. Education completed on 4/7/21. QAPI (Quality Assurance Performance Improvement) Coordinator or designee will monitor, starting 3/29/21, by observing proper hair restraint use from food service staff. After 8 weeks of daily monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months. Results will be reported by dietary manager or designee to the monthly QAPI committee meeting.	4/23/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Sr. Director | (X6) DATE: 4/16/21

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 812	Continued From page 1 §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: Surveyor: 41088 Based on observation, interview and policy review, the provider failed to ensure three of three meal services were completed in a sanitary manner for two of two observed cooks (D and H) who were not wearing hair coverings while serving food to residents in the 100 and 200 hallways. Findings include: Observation and interview on 3/24/21 at 12:07 p.m. with cook H while she was dishing food onto plates from the steam table for residents in the 100 hallway revealed: *She was not wearing a hair covering. *She had worked at the facility for many years. *The food was prepared in the main kitchen located in the connected hospital and brought over to the nursing home to be served in the two kitchenettes. *Hair coverings were not required while serving food in the kitchenettes, only when doing food preparation in the main kitchen. *They were like waitresses, and waitresses did not wear hair coverings to serve food. *People did not wear hair coverings in their homes when serving food. *This was the residents' home and it would not look home-like if they wore hair coverings. *This had always been their policy. Surveyor: 41895 Observation and interview on 3/23/21 at 12:13 p.m. with cook D while she was dishing food onto	F 812		

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F 812	Continued From page 2	F 812		

plates from the steam table for residents in the 200 hallway revealed she:
*Had not been wearing a hair covering.
*Only wore a hair covering in the main kitchen.
*Had not been required to wear a hair covering when serving meals from the kitchenette.

Observation on 3/25/21 at 8:15 a.m. with cook D while she was dishing food onto plates from the steam table for residents in the 200 hallway revealed she had not been wearing a hair covering.

Surveyor: 41088
Interview with dietary manager I on 3/25/21 at 10:07 a.m. regarding meal service revealed:
*She confirmed the food was prepared by cooks in the main kitchen in the hospital, put on carts and delivered to the two kitchenettes in the nursing home.
*Cooks D and H had served food in the kitchenette areas on 3/24/21 and had not normally worn hair coverings.
*This had been their policy due to them not doing food preparation in the kitchenettes.
*The cooks in the main kitchen were required to wear hair coverings because they made the food.
*She believed they were following their policy.

Review of the provider's reviewed/revised 10/18/2019 Nutrition and Food Service Dress Attire policy with dietary manager I revealed:
*"Hairnet, black [facility name] baseball-style hat-available for purchase, or black cooks' hat. Hair covering worn in all food preparation areas."
-She agreed there were times the cooks would do simple food preparation in the kitchenette area like making toast.
*"Hair restraints must be worn at all times in the

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F 812	Continued From page 3 NS [nutrition services] department." -She thought their policy had not included the kitchenettes.	F 812		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		4/23/2021

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F 880	Continued From page 4 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on observation, interview, policy review, and reference source review, the provider failed to follow appropriate infection control practices for residents who were on transmission-based precautions with the potential for exposing	F 880		

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F 880	Continued From page 5 residents and staff to serious harm including death. On 3/23/21 at 6:15 p.m. an immediate jeopardy was identified when the provider failed to ensure: A. Masks were discarded or changed when staff left a resident's room who were on transmission-based precautions (widespread). B. Goggles and or faceshields were disinfected after contact with residents on transmission-based precautions (widespread). C. Soiled and clean gowns were covered (widespread). D. Staff caring for residents on transmission-based precautions were competent with putting on and taking off personal protective equipment (PPE) (widespread). E. Residents (3, 4, and 20) who were on transmission-based precaution had their doors closed. F. Six out of six staff (G, N, O, Q, R, T) followed infection prevention practices with residents on transmission-based precautions. G. There were separate stations for staff to put on and take off their PPE to prevent cross contamination (widespread). H. Residents (3, 20, and 30) who exhibited COVID-19 like symptoms were tested per policy. I. Resident's and/or family representatives were educated about transmission-based precautions when sharing a room with a resident requiring precautions (widespread). J. Separation of newly admitted or re-admitted residents (4 and 142) of unknown status were not cohorted with existing residents that did not require precautions. K. Two of two environmental specialists staff (K and L) followed appropriate cleaning and disinfection of resident's rooms (non-immediate jeopardy finding).	F 880		

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F 880	Continued From page 6 L. Two of two certified nursing assistants (M and P) followed appropriate cleaning and disinfection of the two facility whirlpool tubs (non immediate jeopardy finding). These failures have the potential to expose all residents, staff, visiting personnel, and families to illnesses that could lead to serious harm or death. NOTICE: On 3/23/21 at 6:15 p.m. an immediate jeopardy was identified when the provider failed to implement Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19 and other contracted illnesses. Notice of Immediate Jeopardy was given verbally to senior director A (attending via phone), director of nursing services (DNS) C, and infection control preventionist (ICP) B. For Specific immediate jeopardy noncompliance, see above findings; A, B, C, D, E, F, G, H, I, and J. At the above time the senior director was asked for an immediate plan of removal to ensure all staff working with residents who were on transmission-based precautions received education and competencies for nationally recognized infection control procedures. On 3/23/21 at 9:10 p.m. senior director A provided a removal plan per email. The removal plan was accepted on 3/24/21 at 5:27 p.m. with agreed upon changes made by the provider while the surveyors verified the plan and the Immediate Jeopardy removed on 3/24/21 at 5:30 p.m. After removal of the Immediate Jeopardy, the scope/severity of this citation is level "F."	F 880		

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F 880	Continued From page 7 1. Ensure mask worn into resident's rooms who were on transmission-based precautions were discarded or changed after leaving. The masks will discard in the trash can just outside the isolation room. Action: Immediate action was taken. DNS [director of nursing services] and Infection Preventionist began education to staff on discarding of mask after leaving an isolation room and replacing with a new one on 3/23/2021. Education will be provided to all staff to discard their mask after leaving an isolation room and apply a new mask. Directional signage will be placed outside of each isolation room directing staff to remove mask and replace with new mask. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/21. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI [Quality Assurance Process Improvement] Coordinator or designee will monitor, starting 3/24/2021 by observing 5 exits from an isolation room. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee meeting. 2. Disinfect goggles/face shield after contact with residents on transmission-based precautions. Action: Immediate action was taken. DNS and Infection Preventionist began education to staff on 3/23/2021. Education will be provided to all staff for disinfection of goggles/faceshield, by wiping down	F 880	1. A. Ensure mask worn into resident's rooms who were on transmission-based precautions were discarded or changed after leaving. The masks will discard in the trash can just outside the isolation room. A: Action: Immediate action was taken. DNS [director of nursing services] and Infection Preventionist began education to staff on discarding of mask after leaving an isolation room and replacing with a new one on 3/23/2021. Education will be provided to all staff to discard their mask after leaving an isolation room and apply a new mask. Directional signage will be placed outside of each isolation room directing staff to remove mask and replace with new mask. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/21. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI [Quality Assurance Process Improvement] Coordinator or designee will monitor, starting 3/24/2021 by observing 5 exits from an isolation room daily for 8 weeks, then 5 exits each week for 2 months, then 5 exits monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 2. B. Disinfect goggles/face shield after contact with residents on transmission-based precautions.Action: Immediate action was taken. DNS and Infection Preventionist began education to staff on 3/23/2021. Education will be provided to all staff for disinfection of goggles/faceshield, by wiping down with PDI wipes, upon exiting the isolation room, and the importance of clean/dirty seperation.	

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F 880	Continued From page 8 with [product name] wipes, upon exiting the isolation room, and the importance of clean/dirty separation. Staff will be education on the process of disinfecting goggles/face shields. Staff will be educated that goggles/faceshield must hang on hooks provided outside of the door for a minimum of three minutes. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 exits from an isolation room. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee meeting. 3. Soiled and clean gowns will be covered. Action: Immediate action was taken. DNS and Infection Preventionist placed signage on clean gowns and provided education that all clean gowns must be covered. DNS and Infection Preventionist removed overflowing soiled gowns and provided immediate education that soiled gowns could no overflow from soiled linen hamper. Educated staff to change out hamper more frequently. DNS and Infection Preventionist began education to staff on 3/23/2021. Education will be provided to all staff that clean gowns must be covered and marked at all times. Education will be provided to all staff that the soiled linen hamper cannot overflow and should be changed out multiple times throughout the shift. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff	F 880	Staff will be education on the process of disinfecting goggles/face shields. Staff will be educated that goggles/faceshield must hang on hooks provided outside of the door for a minimum of three minutes. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 exits from an isolation room daily for 8 weeks, then 5 exits each week for 2 months then 5 exits monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 3. C. Soiled and clean gowns will be covered. Action: Immediate action was taken. DNS and Infection Preventionist placed signage on clean gowns and provided education that all clean gowns must be covered. DNS and Infection Preventionist removed overflowing soiled gowns and provided immediate education that soiled gowns could no overflow from soiled linen hamper. Educated staff to change out hamper more frequently. DNS and Infection Preventionist began education to staff on 3/23/2021. Education will be provided to all staff that clean gowns must be covered and marked at all times. Education will be provided to all staff that the soiled linen hamper cannot overflow and should be changed out multiple time throughout the shift. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021.	

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F 880	Continued From page 9 will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing clean gowns and soiled linen hamper daily. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee meeting. 4. Staff caring for residents on transmission-based precautions are aware of proper doffing of PPE and proper use, removal and disinfecting of goggles/ face shields. Action: Immediate action was taken by the DNS and Infection Preventionist on 3/23/21. Staff were educated on proper doffing of PPE, including goggles/faceshields. Education will be provided to all staff on doffing. Donning/doffing competency will be reviewed with all staff. Email sent to all direct care staff on 3/23/21 and to all staff on 3/24/21. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/21. Training will be provided to all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 exits from an isolation room. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee meeting. 5. Transmission-based precaution room doors will	F 880	All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 exits from an isolation room daily for 8 weeks, then 5 exits each week for 2 months then 5 exits monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 4. D. Staff caring for residents on transmission-based precautions are aware of proper doffing of PPE and proper use, removal and disinfecting of goggles/ face shields. Action: Immediate action was taken by the DNS and Infection Preventionist on 3/23/21. Staff were educated on proper doffing of PPE, including goggles/ faceshields. Education will be provided to all staff on doffing. Donning/doffing competency will be reviewed with all staff. Email sent to all direct care staff on 3/23/21 and to all staff on 3/24/21. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/21. Training will be provided to all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 exits from an isolation room daily for 8 weeks, then 5 exits each week for 2 months, then 5 exits monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee.	

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F 880	Continued From page 10 be closed. Action: Immediate action was taken. All Isolation doors were closed. DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff that isolation doors must remain closed at all times. If there is a safety concern, clear plastic shower curtains must be used, and staff may reach out to maintenance, administrator, DNS or Infection Preventionist to implement clear shower curtain. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 doors to isolation rooms daily. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee. 6. Infection prevention practices with residents on transmission-based precautions. Action: Immediate action was taken, DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff on proper hand hygiene. A visual aide competency will be provided. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by a signature of staff and witness on competency	F 880	5.E. Transmission-based precaution room doors will closed. Action: Immediate action was taken. All Isolation doors were closed. DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff that isolation doors must remain closed at all times. If there is a safety concern, clear plastic shower curtains must be used, and staff may reach out to maintenance, administrator, DNS or Infection Preventionist to implement clear shower curtain. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor for closed door, starting 3/24/2021, by observing 5 doors to isolation rooms daily for 8 weeks, then 5 doors each week for 2 months, then 5doors monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 6.F. Infection prevention practices with residents on transmission-based precautions. Action: Immediate action was taken, DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff on proper hand hygiene. A visual aide competency will be provided. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by a signature of staff and witness on competency	

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	43A073	A. BUILDING _____ B. WING _____	03/25/2021

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F 880	Continued From page 11 validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/21, by observing 5 hand hygiene opportunities upon entry and exit of a resident room daily. Audits will occur daily for 7 days, weekly for 4 weeks and monthly for 2 months. Results will be reported to the monthly QAPI committee. 7. Separate donning and doffing stations to prevent cross contamination. Action: Immediate action was taken, DNS and Infection Preventionist immediately moved all stations right outside of the isolation room so [product name] wipes can be obtained for cleaning of goggles/faceshields without breaking the clean/dirty barrier. DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff to ensure that clean totes remain with an arms reach outside of the isolation room. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided for all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing 5 exits of isolation room[s] to ensure the clean totes are within reach. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee. 8. Residents who exhibit COVID-19 symptoms will be tested.	F 880	validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/21, by observing 5 hand hygiene opportunities upon entry and exit of a resident room daily for 8 weeks, then 5 observations each week for 2 months the 5 observations monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 7. G.Separate donning and doffing stations to prevent cross contamination.Action: Immediate action was taken, DNS and Infection Preventionist immediately moved all stations right outside of the isolation room so PDI wipes can be obtained for cleaning of goggles/faceshields without breaking the clean/dirty barrier. DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff to ensure that clean totes remain with an arms reach outside of the isolation room. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided for all staff and will be documented by a signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by observing exits of isolation room[s] to ensure the clean totes are within reach. Audits will occur 5 exits from isolation room daily for 8 weeks, then 5 exits each week for 2 months, then 5 exits monthly x 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee.	

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F 880	Continued From page 12 Action: Immediate action was taken. Residents identified were tested and were negative. All negative results were obtained in [on] 3/23/2021. Education will be provided to all staff on signs and symptoms of COVID-19 and immediate testing when symptoms are present. This includes calling the provider on call for an order. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided for all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by reviewing charts of all residents with COVID-19 symptoms to ensure a test has been obtained. All residents with symptoms are reviewed daily by the care center team. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee. 9. Ensure residents and/or family representatives were notified and educated of roommates' transmission-based precaution status. Action: Immediate action was taken. DNS, Infection Preventionist and Nursing Supervisor/MDS Coordinator called all family and educated resident who were their own decision maker of transmission-based precaution status and sign and symptoms to watch for. DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff on calling family representative and educating residents who are their own decision maker of transmission-based precaution status and signs and symptoms to watch for. Email sent to all	F 880	8.H. Residents who exhibit COVID-19 symptoms will be tested. Action: Immediate action was taken. Residents identified were tested and were negative. All negative results were obtained in lab on 3/23/2021. Education will be provided to all staff on signs and symptoms of COVID-19 and immediate testing when symptoms are present. This includes calling the provider on call for an order. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided for all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by reviewing charts of all residents with COVID-19 symptoms to ensure a test has been obtained. All residents with symptoms are reviewed daily by the care center team. Audits will occur daily. After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 9.I. Ensure residents and/or family representatives were notified and educated of roommates' transmission-based precaution status. Action: Immediate action was taken. DNS, Infection Preventionist and Nursing Supervisor/MDS Coordinator called all family and educated resident who were their own decision maker of transmission-based precaution status and sign and symptoms to watch for. DNS and Infection Preventionist began education on 3/23/2021. Education will be provided to all staff on calling family representative and educating residents who are their own decision maker of transmission-based precaution status and signs and symptoms to watch for. Email sent to all	

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F 880	Continued From page 13 direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided for all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by reviewing charts of all residents on transmission-based precautions who have roommates to ensure notification has occurred. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the monthly QAPI committee. 10. Ensure separation of newly admitted residents of unknown status were not cohorted with existing residents. Action: New admit residents who are not fully vaccinated are placed on quarantine in a private room for 14 days or until considered fully vaccinated. Education will be provided to all staff on new admission requirements. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by reviewing separation/isolation setup of all new admit residents upon admission. Audits will occur daily for 7 days, weekly for 4 weeks and then monthly for 2 months. Results will be reported to the	F 880	direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided for all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by reviewing charts of all residents on transmission-based precautions who have roommates to ensure notification has occurred. After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 10. J. Ensure separation of newly admitted residents of unknown status were not cohorted with existing residents. Action: New admit residents who are not fully vaccinated are placed on quarantine in a private room for 14 days or until considered fully vaccinated. Education will be provided to all staff on new admission requirements. Email sent to all direct care staff on 3/23/2021 and to all staff on 3/24/2021. All staff will review education and sign with a witness prior to the start of their next shift. Training was started on 3/23/2021. Training will be provided to all staff and will be documented by signature of staff and witness on competency validation. All staff will review education and sign with a witness prior to the start of their next shift. QAPI Coordinator or designee will monitor, starting 3/24/2021, by reviewing separation/isolation setup of all new admit residents upon admission. Audits will occur daily. After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee. 4/12/21 Contact made with consultant, RN/Lead Infection Prevention Specialist.	

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F 880	Continued From page 14 monthly QAPI committee. As of 3/24/2021 at 3:15 p.m., the above items have been implemented." Findings include: A. Interview on 3/23/21 at 11:15 a.m. with facility staff including senior director A, DNS C, and ICP B revealed: *They had two residents on quarantine. One was a new admission and the other was a re-admission to the facility. *They had two residents on isolation due to gastrointestinal (GI) symptoms. *It was their expectation for staff to wear gown, goggles, and surgical mask into the isolation and quarantine rooms. -Staff also signed a sheet of paper when they had entered the room, for tracking purposes. *ICP B stated that staff did not change their surgical mask or clean their goggles in between quarantine, isolation rooms, and non-quarantine rooms. -She stated this was because they were in "reuse" status. Observation on 3/23/21 on at 11:48 a.m. of the 100 hallway revealed: *Room 103 was resident 3 and 28's shared room and had an "enhanced barrier precautions" sign outside of the door. *The door was open. *There was a container with a lid that stated "clean gowns" outside the door. *There was a small 3 drawer white container also outside the door. *There was an open container inside the room with what looked like discarded gowns. *Resident 3 was on transmission-based	F 880	QAPI Coordinator contacted Improvement Specialist from SD Quality Improvement Organization on 4/9/21.QIO suggested providing immediate education/ constructive criticism to staff not following policy & procedure, increase frequency of audits, implementing focus area education weekly and continuation of Sanford Higher Reliability training. Facility IC self-assessment completed 4/12/21. Facility assessment plan was reviewed on 4/12/21 with no changes. Additional education provided by consultant, Lead ICP. **Education Plan:** **Date:** 4/12/21 **Center Number/Facility Name:** Sanford Chamberlain LTC **Who and how was education need identified:** Survey DPOC **Education Completed By:** consultant, RN/Lead Infection Prevention Specialist v **Learning Topic:** Infection Prevention and Control v **Attendees/ Department(s):** Senior Director, Infection Prevention Specialist, Director of Nursing, Clinical Quality Specialist v **Meeting Dates/Times:** (Virtual) 4/12/21 v **Topics** o PPE Use- face masks, eye protection, gowns and gloves § Requirements for Contact and Droplet precautions § Donning and Doffing § Storage and Handling o Notification of TBP to resident's roommates o COVID-19 § Symptoms Identification § Testing § Transmission-Based Precautions v **Materials Reviewed** o Emerging Threats Policy o SD PPE Grid o Donning and Doffing Flyer o Hand Hygiene Program o **Track In Success Center:** YES or (N) **Name of Meeting in Success Center: N/A** Changed all practices to follow existing policies as outlined in POC and DPOC.	

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F 880	Continued From page 15 precautions, resident 28 was not. Observation on 3/23/21 at 11:49 a.m. revealed: *Room 100 was resident 4 and 39's room and had a droplet precautions sign outside the door. *There was also a staff sign in sheet that was hanging on the wall that had not been filled out yet. *Their door was also open. *There was a small 3 drawer white container outside the door. *There was a clean gown container outside the door that was partially covered by a towel. *Resident 4 was observed coming out of the door of the shared bathroom, and went back to his side of the room. B. Observation and interview on 3/23/21 at 11:58 a.m. of activities director R revealed: *She went into resident 3 and 28's room, without a face shield or goggles. *The door had remained open. *She walked outside of the room in the hallway and removed her gown. *She placed her gown in the clean gown bin, instead of the dirty gown bin which was inside the room. *She had not removed her surgical mask. *She had removed her soiled gloves and placed them both in her left hand. *She had not performed hand hygiene. *Registered nurse (RN) T informed the Activities director that resident 3 was on isolation due to GI symptoms. *Resident 3 had spiked a fever, vomiting and loose stools. -RN T thought that resident 3 may have had Clostridioides difficile (C. Diff).	F 880	Root Cause Analysis (RCA) completed on 4/12/21 with the Senior Director, LTC DNS, LTC Social Services, QAPI Coordinator, Nurse Consultant, Hospital DNS, ICP, LTC Medical Director & Lead Infection Prevention Specialist Consultant present. RCA led by Lead Infection Prevention Specialist Consultant & QAPI Coordinator. Problem statement: policy & procedure for isolation and food handling not followed. Systematic analysis discovered: * proper education not provided * barrier in communication regarding residents in isolation * GI symptoms not recognized as Covid symptoms * staff didn't escalate severity of illness Corrective action includes: * development of isolation kit & checklist when resident placed on isolation. Nutrition and Food Service Dress Attire policy updated on 3/29/21. * implementation of isolation huddles to be lead by DNS, ICP &Medical Director * educate charge nurse that a change in resident symptoms & potential Covid testing is relayed to provider * educate & empower staff to escalate severity/ urgency of resident illness to provider. 4/15/21 Additional education & training provided at LTC direct care staff meeting. Education & training reiterated as a result of the recent IJ.	

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F 880	Continued From page 16 Surveyor 41088: Observation and interview on 3/23/21 at 12:00 p.m. with activities director R entering and exiting resident 3 and resident 28's shared room revealed: *There was an isolation station set up outside of the room. *No sanitizing wipes or hand sanitizer were observed on the cart. *The door to the room remained open. *Activities director R: -Entered the room wearing a surgical mask and after donning a cloth gown, and gloves. -Gave resident 28 his mail, spoke with him behind the closed curtain by his bed for a few minutes and then exited the room without closing the door. -Had not washed her hands or performed hand hygiene. -Had taken off her cloth gown and placed it into a linen bin marked "clean gowns" outside of the room in the hallway and closed the lid. -Continued to wear the same surgical mask. -Confirmed she forgot to wear eye protection into the room and should have. -Removed her gloves and kept them in her hand. -Thought resident three was the resident on transmission-based precautions because he had readmitted. -She walked away after RN T came up to explain the transmission-based precautions for resident 3 when she overheard the conversation. -Activities director R was observed to carry those same gloves with her while she walked away down the hallway and around the corner. Surveyor 42477: Further observation on 3/23/21 at 12:02 p.m. revealed:	F 880		

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F 880	Continued From page 17 *RN T went into resident 3 and 28's room. -She put on a gown and went inside room 103's open doorway. *She had checked resident 3's blood glucose level. *She had reached in her pocket with her soiled gloves. *She had removed her gown inside the room with the door open. -The soiled gowns were overflowing onto resident 3 and 28's floor. *She had performed hand hygiene with alcohol based hand rub (ABHR). *She had brought the dirty glucometer back down to the nurses station to disinfect it. *The door had remained open. Surveyor 41088: C. Observation and interview on 3/23/21 at 12:05 p.m. with RN T after she exited resident 3 and 28's shared room revealed: *She removed her cloth gown inside of the room and had placed into an uncovered container next to the doorway that was overflowing with gowns. *RN T had not sanitized her goggles when she exited the room. *She had not changed her surgical mask. *She had not washed her hands and hand hygiene was not observed to be done. *Resident 3 had been on precautions because of a gastro-intestinal (GI) issue that had been going around the facility. *He had loose stools and a fever. *They did not think he had COVID-19 and he had not been tested for it. Surveyor 42477: Observation on 3/23/21 at 12:10 p.m. of the rest of the 100 hallway revealed:	F 880		

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F 880	Continued From page 18 *There was isolation container outside of room 104 and 111. *Room 104 had residents 10 and 20 in a shared room, the door was open. *Room 111 had resident 30 in a room, the door was closed. D. Observation on 3/23/21 at 12:16 p.m. of the 200 hallway revealed: *Room 205, which was resident 32 and 142's shared room. *There was a container that had clean gowns, which was partially covered with a towel. *There was a white three-drawer container outside the door. *Sign by the door stated "contact/droplet precautions." *The door was closed. Further observation on 3/23/21 at 12:21 p.m. on the 100 hallway revealed: *Staff were passing room trays to residents in their rooms. *Nurse aide (NA) O, went into room 103 to deliver a tray to resident 28. -She did not put a gown, gloves, and did not take off her surgical mask. --She also did not perform hand hygiene when she left the room. *RN T then put on a gown to deliver a room tray to resident 3 in room 103. *RN T was overheard telling resident 3 that his blood work and urine came back ok, he probably just had a GI bug that was going around. -When she left the room she did not remove her surgical mask or disinfect her goggles, the door remained open. *CNA Q went into room 100 to deliver a room tray to resident 4.	F 880		

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F 880	Continued From page 19 *She did not have a gown on, or goggles. -When she left she did not perform hand hygiene. *RN T, NA O, and CNA Q also went into non-quarantine and non-isolation rooms with the same surgical mask that they wore into the rooms of residents who were on transmission-based precautions. Surveyor 41088: E. Interview on 3/23/21 at 12:30 p.m. with NA O after observation of her entering and exiting resident rooms on transmission-based precautions revealed she: *Was in training to become a CNA and had been scheduled to take the test later in the week on Thursday. *Had been scheduled to train with a CNA each day and worked with CNA Q that day. *Wore a surgical mask and had touched it several times to keep it over her nose. *Stated she had already completed dietary training and infection control classes online. *Reported the hand sanitizer had been removed from the hallways because of a problem with a resident getting into it. *Pointed to a small hand sanitizer bottle attached to her lanyard and stated she used hand sanitizer when exiting resident rooms or would walk down and wash her hands in the dining room or kitchen. *Had not been observed to use hand sanitizer when entering or exiting rooms or to wash hands. *Stated resident 4 was on precautions because he on a home visit and resident 3 was on precautions because he had been vomiting. *The doors to resident 3 and 4's rooms remained open. Observation on 3/23/21 at 12:40 p.m. with CNA Q	F 880		

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F 880	Continued From page 20 after exiting resident 4 and 39's shared room with transmission based precautions revealed: *The door to the room was open. *She carried a cup of water into the room. *She had not put on gloves or a gown. *She had not changed her surgical mask after exit. *She had not sanitized her eye protection after leaving the room. *She had not performed hand hygiene or washed her hands. Surveyor 42477: F. Interview on 3/23/21 at 12:42 p.m. with CNA Q revealed she: *She was a temporary CNA hired through a temp agency. *Had been working in the facility for 8 months. *Was providing training with NA O that day. *Stated staff were supposed to wear a gown, goggles, and surgical masks into quarantine and isolation rooms. *Did not have an answer for why she did not wear a gown into those rooms. G. Observation and Interview on 3/23/21 at 1:14 p.m. of the 200 hallway revealed: *Resident 32 was being brought back to his shared room number 205 with resident 142. *Resident 142 was a newly admitted resident to the facility. -He was on contact/droplet precautions. *Resident 32 was in the main dining room eating with other residents. -He was not wearing a mask. *RN G put on a gown to help CNA's N and E. *She went into resident 32 and 142's room with goggles on the top of her head. *RN T came over from the 100 hall and reached	F 880		

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F 880	Continued From page 21 in the door and grabbed keys from RN G. *RN G came out of room 205 did not clean off her goggles or change her surgical mask. *Clean linen container remained partially uncovered with a towel. *CNA N stated resident 142 was on COVID-19 precautions because he is a new admit. *She said they were supposed to wear a gown, gloves, goggles, and surgical mask. *She said they were not supposed to clean off their goggles or change their surgical mask. *CNA N stated they were supposed to sign the sign in sheet when they went into the room that way if resident 142 developed COVID-19, they will know who had been in contact with him. -CNA N had signed the sheet earlier that day. --CNA E did not sign the sign in sheet. *RN G was not sure why resident 32 had been placed with resident 142, they did have an open room available. Review of the sign in sheet by resident 32 and 142's door revealed: *The date on the sheet stated "3/15/21" *There were four people that have signed into the room in eight days: -One staff member on 3/15/21. -One staff member on 3/18/21. -One staff member on 3/22/21. -One staff member on 3/23/21. H. Interview on 3/23/21 at 3:28 p.m. with DNS C and ICP B revealed: *ICP B had been in her role for 16 years at the facility. *DNS C had been at the facility for 16 years, but had been the DNS for 5 weeks. -She previously worked as a charge nurse in the facility.	F 880		

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F 880	Continued From page 22 *They leave it up to the Physician regarding testing residents for COVID-19. *Resident's 3, 20, and 30 were having GI symptoms, including low grade temperatures. *They did not know if they had standing orders or prn (as needed) orders for COVID testing. *Staff were expected to wear gown, gloves, goggles, and masks for contact/droplet precautions. *Staff were expected to remove gown before leaving the room. *ICP B stated staff are not required to change their masks because they are currently in conservation status at the facility. *Conservation status came from the corporate level. -ICP B had not known when they were told they were in conservation status. *Nursing staff are given a new mask daily. *Office staff get a new mask every five days. -They have had a hard time getting masks. *Surveyors asked if they had reached out to the South Dakota Department of Health (SD DOH) for supplies. -ICP B stated they did a long time ago, she did not know when they last submitted a request for PPE. *For residents on droplet/contact precautions it is preferred that their door is closed. -At times the doors are left open for safety reasons. *Cohorting residents had been challenge. -They have not had a cohort zone. *They believed resident's roommates were informed and educated on being roomed with someone on transmission-based precautions. -If so, it would have been documented in the electronic health record (EHR). *Nurses have been fit-tested for N95 masks.	F 880		

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F 880	Continued From page 23 *They are able to fit test other staff if needed. *ICP B stated they are not changing masks because the policy said if using a face shield they do not need to change masks. *ICP B and DNS C agreed staff have been wearing goggles and should change their masks. *ICP B and DNS C agreed if staff needed to reuse surgical masks then their policy stated they need to fold them and store them in a paper bag outside of the resident's room. Surveyor 41895: Interview on 3/23/21 at 4:47 p.m. with CNA E on disinfecting her goggles after exiting a resident's room who was on transmission based precautions revealed she: *Wiped her goggles with a paper towel in the residents room if they were soiled. *Agreed the goggles could be contaminated. *Did not know she needed to disinfect the goggles. *Did not know where or how to disinfect the goggles. Interview on 3/23/21 at 4:48 p.m. with CNA F on disinfecting her face shield after exiting a resident's room who was on transmission based precautions revealed she would walk to the nurses station and use the disinfecting wipes kept in the cupboard to disinfect her face shield or goggles. There had not been disinfecting wipes available outside resident rooms. Surveyor 42477: Further interview on 3/23/21 at 4:49 p.m. with ICP B and DNS C revealed: *Family and resident notification on cohorting quarantine residents and non quarantine residents has not been done.	F 880		

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F 880	Continued From page 24 *All residents do have a standing order for COVID-19 testing. -Some of the newer residents have not had the EHR updated yet. Entered the facility on 3/24/21 at 7:15 a.m. surveyors were informed that there were additional residents with GI symptoms. There was now a total of six residents. I. Observation and interview on 3/24/21 at 10:01 a.m. with environmental specialist (EVS) personnel K revealed she: *Has worked in her current role in the facility for two years. *Went into resident 36's room, wearing a pair of gloves. *Had taken the trash out of the resident's bathroom, bedroom, and grabbed an almost empty toilet paper roll. *Had left the resident room, to go to the housekeeping cart where she: -Put the resident's trash in the waste receptacle. -Grabbed a new roll of toilet paper. *Using the same gloves she originally put on she: -Grabbed all of the resident's soiled linens that were on the floor. -Placed them in soiled linen hamper. -Reached into her house keeping cart with the same soiled gloves to grab her disinfecting chemical and a toilet cleaning brush. *She said the chemical she uses is a [product company name] disinfectant. *She squirted the chemical on the toilet brush then she: -Cleaned the inside of the resident's toilet bowl. -With that same brush she cleaned off the rim of the toilet, underneath the seat, and on top of the seat.	F 880	I.Sanford policy Standard or Light Cleaning Rehab/Skilled policy reviewed & read as a group -completed 3/26/21. Staff demonstrated proper cleaning of resident room - completed 3/29/21. QAPI (Quality Assurance Performance Improvement) Coordinator or designee will monitor, starting 4/1/21, by observing proper cleaning of resident room by EVS staff. After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by QAPI Coordinator or designee.	4/23/21

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F 880	Continued From page 25 *With the same soiled gloves she went back to the housekeeping cart. *She grabbed a clean towel out of the clean linen bag. *She went back into the resident's room and wiped off his bedside table. -With the same gloves she moved his coffee mug to wipe underneath it. *She wiped off his dresser. *She then removed a piece of chewed bubblegum from the resident's bedside rail. -She took the gum back to the cart to throw it away. -She did not change her gloves. *She then grabbed her mop and mopped the resident's bathroom. *Then vacuumed his room. *She did not clean any high touch surfaces such as door knobs, hand rails, light switches, or remotes. *Surveyor asked if she knew the contact time for the disinfectant that they use. -She wasn't sure but she believed it was 30 minutes. *Surveyor asked if her process is any different for quarantine rooms and she said no she just puts on PPE, but cleans the same. J. Observation and interview on 3/24/21 at 10:42 a.m. with CNA M revealed: *She was cleaning the tub on the 100 hallway. *She said the chemical had been soaking for about 10 minutes. *She scrubbed the surfaces of the tub, then rinsed the sides with the sprayer. *When she was done surveyor asked if she turns on the air jets to finish the cleaning process. -She said that she does not. -She did not know if not turning the air jets on	F 880	J. Visual timers were placed outside each tub room on 3/30/21. Education will be provided to all staff to watch the tub cleaning video and read the standard operating procedure email. Email sent to all direct staff on 3/31/21. Training was started on 4/14/21. Training will be completed 4/14/21 or prior to start of next shift. QAPI Coordinator or designee will monitor proper tub cleaning and timer use starting 3/24/2021. After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by QAPI coordinator or designee.	4/23/21

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F 880	Continued From page 26 was right or not, but that is how she cleaned the tubs. K. Observation and interview on 3/24/21 at 11:45 a.m. on the 200 hallway revealed: *Surveyor asked CNA P if she could observe her disinfect the tub. *CNA P stated the chemical was currently in the tub and she would let the surveyor know when she wouldcontinue the process. *Chemical remained in the tub at 12:03 p.m. as residents on the 200 hallway were being served lunch. *CNA P did not inform the surveyor when and if she finished the process. Further observation on 3/24/21 12:33 p.m. with CNA M revealed she: *Was delivering room trays to residents on the 100 hallway. *Went into resident 37's room, carrying his room tray. *Put his tray down on his bedside table. *Uncovered his drinks and food. *Left the room without performing hand hygiene. *Went into resident 27's room without performing hand hygiene. L. Observation and interview on 3/24/21 at 12:38 p.m. with EVS L revealed she: *Had worked in the facility for a couple of months. *Had a plastic bag with clean rags hanging on the cart. *Went into 15's room, not wearing gloves and gathered: -The trash from his bathroom and bedroom. *Placed trash in trash receptacle on housekeeping cart. *Reached in the cart to grab new trash can liners.	F 880		

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F 880	Continued From page 27 *Did not perform hand hygiene. *Took gloves out of her pocket and put them on. *Put a rag in a "quat chemical" that was in a bucket in the cart. *Grabbed the toilet cleaner and toilet brush from the cart. *Cleaned the sink and wall with the rag she had grabbed from the bucket. *Then went back to the cart to put her soiled rag in the soiled linen bag. *Did not perform hand hygiene or remove her soiled gloves. *Went into resident 15's bathroom and squirted toilet cleaner on the inside of the toilet and the toilet seat. *Cleaned the inside of the toilet bowl with the toilet brush, then: -Cleaned the rim, underneath the lid, and the seat with the same brush. *Went back to the housekeeping cart to put the toilet bowl cleaner and brush away. *Grabbed a mop and mopped the bathroom floor. *Removed her soiled gloves for the first time at 12:47 p.m. *Stated she was done with cleaning resident 15's room. *Did not wipe any surfaces in the resident's room other than the residents sink and toilet. *Did not vacuum his room. *Thought the disinfectant contact time was ten minutes but she "wasn't sure." Interview on 3/24/21 at 3:36 p.m. with supervisor plant operations, plant maintenance, and repair J revealed: *He had been at the facility for four years. *He had been in his current role for one month. *He supervised the EVS staff. *Surveyor asked if they had completed audits on	F 880		

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F 880	Continued From page 28 the EVS staff. *He stated that the EVS staff do peer reviews on each other. -Those peer reviews are then brought to QAPI. *He agreed with surveyors concerns regarding the process of cleaning resident's rooms. *He stated that he would be addressing the concerns. Review of providers February 2020 standard and transmission based precautions (isolation) policy revealed: *"Purpose: Standard and transmission based precautions are used to prevent transmission of infectious diseases. To provide for protection of patients and visitors from the spread of illness and disease. To minimize or eliminate occupational risk associated with exposure to infectious illness and disease. To describe the appropriate practices and procedures for Standard Precautions and transmission based precaution categories." *"Standard Precautions will be followed for all patients, in all locations at all times." *"Transmission-based precautions (e.g., Contact, Droplet, and Airborne) will be implemented for suspected or diagnosed infections. All personnel that enter the room must adhere to the precautions. Precautions will be discontinued per the recommended duration of the precautions." *"Hand Hygiene is the single most important procedure for interrupting transmission of infections to patients and employees." Further review of provider's February 2020 standard and transmission based precautions (isolation) policy, in particular Contact GI precautions revealed: *"Hand washing with soap and water is required	F 880		

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F 880	Continued From page 29 after patient contact and when leaving the room." *"A private room is optimal." *"Cohorting by placing two patients with the same organism together may be possible. Contact Infection Preventionist for information regarding cohorting." *"Surgical mask must be worn when entering the room. Visitors are highly encouraged to wear a mask. Remove and dispose of mask when leaving the room." Review of provider's February 2012 standard operating procedures for cleaning care center ancillary areas revealed: *"All Environmental Specialists will follow this procedure for cleaning ancillary areas." *Daily cleaning of residents rooms: -"Damp wipe door handles, windowsills, light switches[.]" -"Empty trash container; wipe with quaternary disinfectant and reline." -"Wash off surfaces readjust nick knacks ext. [etc.]." -"Dust TV with damp cloth unless otherwise instructed." -"Spot check walls[.]" -"Vacuum carpet daily (spot shampoo stains report if they wont remove)." Review of provider's august 2011 standard operating procedures for cleaning patient or resident bathroom revealed: *"All Environmental Specialists will follow this procedure for cleaning Patient or resident bathrooms." *"PPE: Vinyl or non-latex gloves are to be worn at all times while cleaning a bathroom. Always wash hands and change gloved after cleaning a patient bathroom."	F 880		

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F 880	Continued From page 30 *"Quaternary disinfectant is to be used for a disinfectant unless there is a level C quarantine posted [.] In that event a 1:10 bleach solution or dispatch should be used." *"Put toilet bowl cleaner on Johnny mop [toilet mop/brush] the size of a dime. Start on inside rim, and on down into water, push water through toilet trap, when completed flush toilet. (individual jonnie [johnny] mops are to be provided for individuals with special precautions in care center) after terminal cleaning jonnie [johnny] mop is to be discarded[.]" *"Damp wipe all stainless steel pipes, fixtures, and porcelain area and toilet seat with quaternary disinfectant." *"Rags used to clean the toilet should not be used to clean any other object in the room." *"Damp wipe toilet paper dispenser, replenish as necessary." *"General Waste: If there are any trash containers in this area, empty and damp wipe the interior and exterior with a quaternary disinfectant and reline with fresh plastic liner. At no time should the contents of the trash container be touched." *Policy then stated, "Cleaning remaining area of bathroom." -That was the last statement and the last page of the provided document. Review of the provider's Environmental Services Occupied Room Checklist revealed: *"Vacuum room when residents are not present! Vacuuming room during breakfast and lunch then going back and cleaning bathrooms will be the best way not to disturb or disrupt resident daily routines and give them their privacy (report unusual odors) [.]" *"SANATIZE [Sanitize] HANDS AND PUT ON	F 880		

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F 880	Continued From page 31 GLOVES." *Daily disinfection of surfaces in the bathroom which included: -Door handles. -Bathroom Shelves. -Mirror. -Disinfect sink, Faucet and handles. -Toilet plumbing/handle. -Assistant hand rails. -Toilet seat top and bottom. -Toilet seat risers. -Use toilet chemical to clean toilet. -"(individual jonny [johnny] mop is to be provided for individual with special precautions," *Staff are then supposed to remove gloves and sanitize hands. *Staff are then supposed to: -Restock toilet paper. -Restock paper towels. -Restock hand soap. --"(Use gloves) Change sharps container if needed." -Mop floor. -Mop, or vacuum- Check under bed. -Wash off surfaces, readjust nick [knick] knacks ext.[etc.] -Empty trash disinfect as needed replace liner. -Wash off Door handles. -Wash off Light switches. -Dust TV with damp cloth unless otherwise instructed. -Spot check walls. Review of provider's signs taped on both facility tubs revealed: *"Cleaning of Whirlpool." *"DO NOT ADD ANY WATER." *"Clean after every bath as follows." *"Push and hold disinfectant button to [so] you	F 880		

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F 880	Continued From page 32 have 1-1 1/2 Gallon[s] of solution in the well. Almost up to the black circle in the well. Scrub all surfaces of the tub and seat and let sit for 10 minutes. Remove plug, rinse tub and chair. Push and hold Rinse button until clear water comes out of the [typo] all air jets. Rinse all areas of tub. Push Aqua Air for 30 seconds or if last bath 2 minutes. If 1 or more hours between baths wipe all areas down with a towel and leave door open." Review of the manufacture's Safe Operation and Daily Maintenance Instructions for the facility tubs revealed: *"System Cleaning (After Every Bath)" *"Clean and disinfect the tub after every bath with [manufacturer's name] Cleaner/Disinfectant as follows:" -"Close and lock the door." -"Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness." -"Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tub surfaces with the shower sprayer." -"Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain." -"Press and hold the Disinfect Button located on the top of the tub shown in (figure 1). As the button is held down, the properly mixed cleaning solution is running through the air injection system and out all of the air jets. Release the button after you see solution coming out of all the air jets and you have 1 to 1 1/2 gallons of disinfectant solution in the foot well of the tub." -"Using the long-handled brush, available from your [manufacturer's name] distributor, thoroughly	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	03/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 scrub all interior surfaces of the tub with the solution that remains in the foot of the well of the tub. Let disinfectant stay on surface for 10 minutes. (Or, as recommended by the instructions on the disinfectant concentrate container.)" -"Remove the plug from the drain." -"Rinse most of the soapy water away with the shower sprayer." -"Press and hold the Rinse button located on the control panel shown in (figure 1) until clear water runs from all the air jets. Then release the Rinse button." -"Finish rinsing the interior surfaced of the tub with the shower sprayer." -"Start the air blower by pushing the Aqua-Aire button. Allow it to run for 30 seconds. This pushes the rinse water out of the air injection system. If this was the last bath of the day, allow the blower to run for 2 minutes to dry out the system." -"Stop the Aqua-Aire blower by again pushing the Aqua-Aire button on the control panel as shown in (figure 1)." -"Visibly check the tub was effectively cleaned during the disinfecting procedure. If not, repeat the procedure." Review of the [product company name] technical data sheet for the toilet disinfectant revealed: *"Non-Acid Toilet Bowl Disinfection/Cleaner Directions": -"Remove gross filth prior to disinfection." -"From use-solution: Empty toilet bowl or urinal and apply use-solution to exposed surfaces and under the rim, allow to stand for 10 minutes and flush." *For Virucidal Activity: -"This product when used on environmental,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 880	Continued From page 34 inanimate, hard, non-porous surfaces exhibits effective virucidal activity against the pathogens listed below. For heavily-soiled areas, a pre-cleaning step is required. Apply solution with a cloth, mop, sponge, hand pump trigger sprayer or low pressure coarse sprayer so as to wet all surfaces thoroughly. Allow the surface to remain wet for 10 minutes, then remove excess liquid." Review of the [product company name] technical data sheet for the Quat disinfectant revealed: *"Disinfection/Cleaning/Deodorizing Directions": -"Remove heavy soil deposits from surface. Then thoroughly wet surface with a use-solution of 1/2 ounce of concentrate per gallon of water or equivalent. The use-solution can be applied with a cloth, mop, sponge, or coarse spray device. Spray 6-8 inches from the surface; rub with a brush, cloth or sponge. Do not breathe spray. Let solution remain on surface for a minimum of 10 minutes. Rinse or allow to air dry. Rinsing of floors is not necessary unless they are to be waxed or polished. Food contact surfaces must be thoroughly rinsed with potable water. This product must not be used to clean the following food contact surfaces..." Surveyor: 41088 Surveyor: 41895 Review of the provider's 11/10/20 Infection Prevention Program Surveillance policy revealed: *"[Provider name] Long Term Care will establish and maintain and infection control surveillance program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable disease and infections.	F 880		

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	43A073	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 *Infection and Control Program will establish a system to prevent, identify, report, investigate, and control infections and communicable diseases for all residents, staff, volunteers, and other individuals providing services under a contractual arrangement based upon facility assessment... *Standard and transmission based isolation precautions will be implemented per policy..." Review of the provider's 3/9/21 Emerging Threats - Acute Respiratory Syndromes Coronavirus (COVID) policy revealed: *"Nursing staff will wear proper PPE while cleaning reusable medical equipment prior to removal from the room. *Place reusable cleaning cloths and mop heads in plastic bags before exiting the room and do not reuse in other area or rooms until properly washed and sanitized." *When a resident was identified as suspected or positive COVID-19 they should have been isolated in their room with the door shut. *When staff entered an isolation room they were to wear PPE which included gloves, gown, eye protection, and face mask. *"Reusable eye protection will be cleaned and disinfected according to manufacturer's recommendation. *Hand hygiene will be performed, using a 60-95% alcohol based hand sanitizer, before and after all patient contact, contact with infectious material and before and after removal of PPE, including gloves. *Environmental service personnel will wear proper PPE while cleaning environmental surfaces and reusable equipment. *Face shield should be labeled with your name and can be cleaned and reused multiple times.	F 880		

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	43A073	A. BUILDING _____ B. WING _____	03/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 36 *The same surgical mask may be worn for repeated encounters with multiple patients in the same cohort zone, without removing the surgical mask between patients. *If state guidelines allow, the same surgical mask may be used continuously between zones if protected by a face shield and the face shield is disinfected between zones. *The same eye protection may be used for repeated encounters with multiple residents in the same cohort zone or reused after disinfection between cohort zones."	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING _____ B. WING _____	03/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments Surveyor: 41088 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 from 3/23/21 through 3/25/21. Sanford Chamberlain Care Center was found in compliance.	E 000		

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

TITLE: Sr. Director

(X6) DATE: 4/16/21

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A073	A. BUILDING 02 - BUILDING 2 REPLACEMENT BLDG B. WING _____	03/23/2021

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

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/23/21. Sanford Chamberlain Care Center was found not in compliance with 42 CFR 483.70 (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 the deficiency identified at K161 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 161 SS=D	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered	K 161	The fire caulking was done on 3/26/21 and the Thermal pins arrived and installed 3/30/21. Education provided to staff for pin striking upwards and downwards as well as patch hole in walls. Education to be completed 4/12/21 or at the beginning of next shift. Weekly audits for a month then monthly for 3 months. Results will be reported to monthly QAPI monthly meeting.	4/12/21

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

TITLE: Sr. Director

(X6) DATE: 4/16/21

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.

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 _____	**03/23/2021**

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

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K 161	Continued From page 1 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the fire-resistive design of one of one horizontal exit and building separation wall (between the nursing home building and the hospital). Findings include: 1. Observation at 11:15 a.m. on 3/23/21 revealed the two-hour, fire-rated separation wall between the nursing home building and the hospital had ninety-minute, fire-rated wood doors that only had one point of latching. The panic bar hardware had a rod extending upward to a strike plate in the door frame. A rod had not been installed downward from the panic bar hardware to a strike plate in the floor. The hardware was designed for the installation of both latching rods and strikers.	K 161		

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	43A073	A. BUILDING **02 - BUILDING 2 REPLACEMENT BLDG** B. WING _____	**03/23/2021**

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K 161	Continued From page 2 Interview at 11:20 a.m. on 3/23/21 with the maintenance supervisor confirmed that condition. He verified that a thermal pin could be installed in the lower half of the two door leaves to satisfy the latching requirement. 2. Observation at 11:20 a.m. on 3/23/21 revealed the two-hour fire-rated separation wall between the nursing home and the hospital had a two-inch by four-inch opening above the lay-in ceiling with computer cables extending through it. The hole de-rated the two-hour fire-rated wall since it was not sealed with an approved firestop material. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He added he had been employed in that position less than one month prior to the survey. The deficiency could affect 100% of the occupants of the smoke compartment.	K 161		

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
	10606	A. BUILDING: _____ B. WING _____	03/25/2021

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

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S 000	Compliance/Noncompliance Statement Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/23/21 through 3/25/21. Sanford Chamberlain Care Center was found not in compliance with the following requirements: S127.	S 000		
S 127	44:73:02:06 Housekeeping Cleaning Methods and Equipment The facility shall establish written housekeeping procedures for the cleaning of all areas in the facility and copies made available to all housekeeping personnel. All parts of the facility shall be kept clean, neat, and free of visible soil, litter, and rubbish. Equipment and supplies shall be provided for cleaning of all surfaces. Such equipment shall be maintained in a safe, sanitary condition. Hazardous cleaning solutions, chemicals, poisons, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other cleaning materials. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 42477 Based on observation and interview the provider failed to ensure 2 of 2 facility tub rooms and chemicals remained locked and not accessible to residents. Findings include: 1. Observation on 3/24/21 at 9:35 a.m. of the tub room on the facility's 100 hallway revealed: *The door to the tub room was unlocked and unattended. *There was a chemical out on the shelf above the clean linens.	S 127	Immediate education started by the QAPI coordinator or designee on 3/26/21. Email education was sent out by DNS on 3/31/21 to all direct care staff. New locks were installed on 4/9/21. Training was started on 4/12/21 on reviewing standard operating procedure for locking supply cabinet. Training will be provided to all direct care staff on 4/12/21 or prior to the start of their next shift. Audits will occur daily for 8 weeks, then weekly for 2 months, then monthly for 2 months. Monthly monitoring will continue at a minimum 4 months. Results will be reported to monthly QAPI committee by DNS or designee.	4/23/2021

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

TITLE: Sr. Director

(X6) DATE: 4/16/21

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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
	10606	A. BUILDING: _____ B. WING _____	03/25/2021

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S 127	Continued From page 1 *There was an electric razor out on the 3 drawer container. *There was a cabinet that had a sign that stated: -"Every shift please remember to restock and lock cabinet when done. Thank you." *The cabinet was unlocked. *There was a jug of yellow whirlpool cleaner. *There were various shampoo bottles, conditioner, bottles and bath additive in the cabinet. *There were sodium chloride [product name] tubes. *The door was still unlocked and unattended at 10 a.m. Further observation on 3/24/21 at 10:44 a.m. with CNA M revealed: *She went into the unlocked 100 hallway tub room to clean the tub. *The tub room remained unlocked and the cabinet unlocked when she had finished cleaning, and left the room. Observation on 3/24/21 at 11:56 p.m. of the tub room on the facility's 200 hallway revealed: *The door to the tub room was unlocked and unattended. *There was a pair of nail clippers out on the shelf. *There was an unlocked cabinet that contained chemicals and various open shampoo bottles, body wash, and lotion. *There was a sign on the door of the cabinet informing staff to lock cabinet. *At 5:53 p.m. the tub room and cabinet remained unlocked. Interview on 3/25/21 at 5:26 p.m. with DNS C revealed: *The tub rooms on both hallways should be locked.	S 127		

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
	10606	A. BUILDING: _____ B. WING _____	03/25/2021

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S 127	Continued From page 2 *The cabinet in the tub room should also be locked when not attended. Interview on 3/25/21 at 5:35 p.m. with senior director A revealed that she would expect the tub rooms to be locked when unattended.	S 127		
S 000	Compliance/Noncompliance Statement Surveyor: 41088 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 3/23/21 through 3/25/21. Sanford Chamberlain Care Center was found in compliance.	S 000		