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	43A098	A. BUILDING _____ B. WING _____	05/05/2022

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

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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 5/3/22 through 5/5/22. Sanford Care Center Vermillion was found not in compliance with the following requirements: F609, F679, and F880.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(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 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.	F 609	F609 1.The Regional Clinical Services Director will provide the DON, Social Worker and Senior Director education on reporting requirements by 6/2/22. Social Worker O will do staff education by 6/2/22 on incident reporting with emphasis on reporting immediately or no less than 2 hours to the Social Worker or designee all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property or not less than 24 hours if allegations do not involve abuse and do not result in serious bodily injury. 2.Social Worker O will review incident reports of last 3 months by 5/31/22 to identify any incidents reports that were not reported to DOH that should have been and report findings at 6/1/22 IDT meeting. Social Worker O or designee will also listen to morning shift reports and do daily rounding with nursing staff to inquire of any incidents that may have occurred that had not been reported yet. Social Worker O will also develop agenda to include review of incidents that will be used during daily huddle with IDT staff to be implemented by 6/10/22. 3.Social worker O will ensure initial reports are submitted to SD DOH and any other agencies as appropriate within the 2 hour or 24 hour timeframe as appropriate. Social Worker O will create a quick reference guide to post at the nurses station for staff to reference what to do	6/8/22 6/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 5/24/22

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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to report an incident of resident to resident nonconsensual sexual contact for one of one sampled resident (50) to the South Dakota Department of Health (SD DOH) within 2 hours required for abuse allegations. Findings include: 1. Observation and interview on 5/3/22 at 11:45 a.m. revealed: *Resident 50 was positioned sideways next to a dining table with a meal tray in front of her in the neighborhood dining area while seated in her wheelchair with her legs elevated and extended on leg and foot rests. Her eyes were closed. *The certified nursing assistant (CNA) that was assisting another resident at the same table confirmed resident 50 was asleep. Observation and interview on 5/3/22 at 3:45 p.m. revealed: *Resident 50 was positioned sideways next to the birdcage in the neighborhood dining area. *Her eyes were open, and she was repetitively saying, "Help me." *When asked what she needed, the resident did not provide further explanation. Interview on 5/3/22 at 4:28 p.m. with resident 50's representative revealed: *He received a report that "someone witnessed" a "male resident was molesting her" and "let him know" about it. *That happened "about 6 months ago" and he had "never heard what was done about it." Review of the facility report on file with the SD	F 609	for non-fall incidents by 6/10/22. A copy of the staff education that Social Worker O provided is also available at the nurses station for staff reference on incident reporting along with the DOH flowcharts for reportable incidents. 4. DON and/or designee will audit the timeliness of DOH reports weekly x2, then every other week x2 and then monthly x2 and report results at weekly IDT meeting and quarterly to QAPI committee who will determine ongoing monitoring and interventions.	VS 6/8/22 6/2/2022

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F 609	Continued From page 2 DOH revealed: *An incident that involved a male resident (19) and resident 50 occurred on a Sunday, 12/19/21, at approximately 9:30 a.m. *The initial report from the provider to the SD DOH was submitted on Wednesday, 12/22/21, at 1:43 p.m. *The provider submitted the final report with a completed investigation on Friday, 12/24/21, at 3:00 p.m. *Resident 19 was relocated to a different room in another wing where staff presence is more frequent, and the provider reached out to his physician for treatment options. Review of progress notes (PNs) in resident 50's electronic medical record (EMR) revealed: *There were no PNs documented on 12/19/21, the date of the incident. *A social service PN on 12/22/21 documented: -"On 12/19/21 in AM [morning] (between 9AM and 11AM, although exact time is unknown)" a CNA witnessed the resident 19 approach resident 50 while she was seated in the neighborhood dining area. -He "did a quick scan of the area," walked up to resident 50, and then sexually touched her. -The CNA interrupted the resident contact and he left the area to his room. -The "CNA did report this to the nurse on duty at the time of the incident." -Resident 50 "did not appear to have any negative reaction to this event and did not respond in the moment." -Certified social worker (CSW) O "contacted [the resident's] family on [Tuesday] 12/21/21 to describe above incident." Further review of resident 50's EMR revealed:	F 609		

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F 609	Continued From page 3 *The 2/9/22 minimum data set (MDS) assessment coded the resident as moderately cognitively impaired and totally dependent on staff for physical movement with a limitation in arm movement on one side. *The 2/9/22 care area assessment (CAA) documentation noted: -Her cognition "is generally poor day-to-day," she can make her needs known "at times, but staff have taken on a stronger role in reference to anticipating or asking her about her needs." -She needs "extensive/total" assistance with all activities and "does not walk." Review of resident 19's EMR revealed: *The 10/13/21 and 1/6/22 MDS assessments coded the resident as severely cognitively impaired and independent without staff oversight for all activities related to transferring between surfaces, walking, dressing, and toileting. *A Physician Order Report noted an order dated 12/28/21 for a "psych consult r/t [related to] sexual behaviors." *A psychiatry progress note dated 1/6/22 noted: -The resident was seen for "an evaluation of sexual disinhibition with dementia." -"He is pleasantly confused showing great difficulty recalling recent remote history." -When asked about the recent incident involving resident 50, "he states he would not do that and hoped provider believed that is not his values." Interview on 5/4/22 at 4:45 p.m. with CSW O revealed: *The CNA that witnessed it reported the incident "to me on Monday." *The incident "happened over the weekend" so the report to the state was late. * Staff have been educated to call her as soon as	F 609		

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F 609	Continued From page 4 possible "when something like this happens," but she has had to "re-educate every once in a while." *She agreed "perhaps there should have been" a nursing physical exam after the incident. Interview on 5/5/22 at 10:34 a.m. with director of nursing B, who was not an employee for this provider at the time of the incident, revealed she "absolutely" would have expected the nurse to do a physical exam after the incident occurred. Review of the provider's Abuse and Neglect policy and procedure revealed: *"Any and all persons who have reasonable cause to believe a resident/patient of this facility is being subjected to abuse and/or neglect..,are responsible to report such suspicions." *The procedure to report a suspicion of abuse included, "immediately notify the Senior Director, Directory [sic] of Nursing (DON), LTC [long term care] Director of Nursing or Social Worker. If an incident occurs outside their regular hours, report to the supervising nurse who will assure reporting to the senior Director of DON." *"An initial report is made within 2 hours if serious bodily injury or within 24 hours for all other reports."	F 609		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities,	F 679	F679 1.Activities Supervisor added individual care plan for activities for Resident 21 by 5/23/22. 2.Activities Supervisor reviewed all resident's care plans on SCU to ensure individualized care plans for activities were complete by 6/1/22.	

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F 679	Continued From page 5 designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by. Based on observation, interview, record review, and policy review, the provider failed to provide an individualized activity program for one of nine resident (21) on the special care unit (SCU). Findings include: 1. Observation on 5/3/22 from 3:51 p.m. to 4:10 p.m. on the SCU revealed resident 21 wandering in the hallway. The May 2022 activity calendar posted in the dining room listed the 4:00 p.m. activity as "Sing Along." There was no activity program conducted at 4:00 p.m. Observation on 5/4/22 at 8:41 a.m. on the SCU revealed resident 21 sitting in a lounge chair in the common area. The resident got up from the chair and walked down the length of the hallway and turned around to walk back. There was no activity programming being offered on the SCU at that time. Observation on 5/4/22 at 10:48 a.m. on the SCU revealed activities assistant (AA) V at a table in dining area with one unidentified resident. The activity calendar listed the 10:30 a.m. activity as "Art with [AA V's first name]." AA V was using colored paper and talking to the one resident, but the resident was not physically involved in the activity. Resident 21 was sitting in a lounge chair in the common area, but was not involved in the activity. AA V made no attempt to include resident 21 or the other residents in the common area.	F 679	3. All residents on SCU have an individualized personal activity kit that staff may utilize at any time for one on one personalized activities. Activities Supervisor will educate all SCU staff by 6/2/22 on when and how to use the personalized activity kits for each resident. 4. Activity Supervisor and/or designee will audit at least 3 residents per week on SCU for 2 weeks, then every other week x2 and then monthly x2 to ensure activities are occurring as scheduled and unscheduled activities are documented. Activities Supervisor and/or designee will also do drop in observations across all shifts to ensure staff are engaging with residents and utilizing the individual activity kits for a period of 3 months. The Activities Supervisor will report audit findings weekly at IDT meeting and quarterly to QAPI committee who will determine ongoing monitoring and interventions.	6/2/22

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F 679	Continued From page 6 Interview on 5/4/22 at 11:05 a.m. with activity coordinator M revealed: *She was responsible for the activity programming including the activity calendar for the SCU. *An AA was on the SCU unit for the mid-morning activities on Tuesday, Wednesday, and Friday and on weekday afternoons for the 4:00 p.m. activity. *There were two certified nursing assistants (CNAs) that provided activities throughout the day and on the weekends. *When residents admit to the SCU, she provided the family with a questionnaire to obtain information on the new resident's prior life and activity interests. Interview on 5/4/22 at 11:28 a.m. with director of nursing B and education coordinator N revealed: *CNA D, who was also a certified medication assistant (CMA), was a lead staff person on the SCU. *Both stated there were "usually a lot of activities" on the SCU. Interview on 5/4/22 at 11:44 a.m. with certified social worker O revealed the management of the SCU was an interdisciplinary team effort that involved nursing, dietary, activities, and social services. Review of resident 21's medical record revealed: *She was admitted on 3/2/22 to the SCU. *Her 3/11/22 admission minimum data set (MDS) assessment stated her need for activities would be addressed on her care plan. *Her 3/17/22 care plan had no problem, goal, or approaches addressing her activity need.	F 679		

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F 679	Continued From page 7 Interview on 5/4/22 at 5:24 p.m. with MDS coordinator/infection preventionist C revealed: *The activities department usually completes the MDS assessment for activities and develops the activity care plan. *She was the back-up for the activity department to ensure the MDS and care plan were completed. *She stated there was a mix-up in communication that resulted in the care plan not being completed. *She confirmed there was no activity care plan for resident 21. Interview on 5/5/22 at 10:51 a.m. with CNA/CMA D revealed: *The SCU staff had not usually followed the programs listed on the activity calendar. *The 10:00 a.m. and 4:00 p.m. activity were conducted by one of three AAs on specific days. *The AA or SCU staff had not conducted an activity program that morning. *Activity programming on the weekends had not occurred "very often." Review of the provider's 11/13/21 "Screening And Admission to Special Care Unit" policy revealed: *Purposeful activities would be integrated into the structured daily routine by nursing staff (CNAs) and activity staff. *Activities provided would reflect each resident's prior occupation, interest, and lifestyle as much as was feasible. *Daily routines would be structured seven days per week, recognizing the residents' need for therapeutic programming for all waking hours and at night when they awaken. *Specific activities or interventions to distract or	F 679		

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F 679	Continued From page 8 occupy residents would be explored.	F 679		
F 880 SS=D	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 reported; (iii) Standard and transmission-based precautions	F 880	F880 1.For the identification of lack of: *Appropriate hand hygiene and glove use during tasks that included personal cares and assisted dining *Appropriate procedural technique for sanitizing the mechanical lift between residents. The DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for glove use during cares and assisted dining. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 6/2/22 by the Education Coordinator and/or designee. 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate hand hygiene and glove uses during identified tasks. *Appropriate procedural technique for sanitizing mechanical lift between residents Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 6/2/22 by the Education Coordinator and/or designee. 3. Hand hygiene Root cause analysis conducted by answering the 5 Whys was completed on 5/20/22 by the DON, infection preventionist, education coordinator and improvement advisors. Action plans from RCA include DON ordering pocket size hand sanitizers for staff on SCU since sanitizers are not located outside each resident room there;	

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F 880	Continued From page 9 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: Based on observation, interview, and policy review, the provider failed to ensure proper hand hygiene was performed by 3 of 3 certified nursing assistants (D, G, and H) observed while performing care tasks. Findings include: 1. Observation on 5/3/22 at 9:23 a.m. while certified nursing assistant (CNA)/certified	F 880	completion of hand hygiene audits and monitoring by RNs to include observing cares, dining assistance and in/out of resident rooms. DON will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. The Improvement Advisor contacted the South Dakota Quality Improvement Organization (QIN) on 5/19/22 and discussed ideas for plans of correction and staff education resources for hand hygiene issues. 4. RNs will conduct hand hygiene compliance auditing and monitoring to include 1 per shift observing cares, dining assistance and/or in/out of resident rooms to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment and staff compliance in the above identified areas. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by the DON, and/or a designee to the weekly IDT meeting and quarterly to the QAPI committee to determine ongoing monitoring and interventions.	6/2/22

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F 880	Continued From page 10 medication assistant (CMA) D performed personal care for resident #4 revealed she: *Put gloves on, adjusted resident 4's clothing and removed the wet incontinent product. *Using the same gloves hand, put one hand into a tub of A & D ointment and applied it to the resident's peri-area and then discarded that glove. *Without washing her hands, positioned a new incontinent product and adjusted the resident's clothing, then removed her other glove. *Took the garbage bag out of the garbage can, without gloves on, tied it shut and carried it with her while pushing resident 4 in her w/c towards the day room. -Stopped at the dirty utility room and discarded the garbage bag, and then washed her hands. *Pushed the resident w/c the rest of the way to the day room. *Went to the medication cart and used alcohol hand gel sanitizer on her hands. Interview on 5/3/22 at 9:50 a.m. with CNA/CMA D, revealed: *She agreed she had missed several opportunities for hand hygiene and glove changes. *She replied she "usually does hand hygiene at the appropriate times." Interview on 5/5/22 at 12:40 p.m. with the director of nursing (DON) B, when asked about the above observation, revealed: *She agreed there had been several missed hand hygiene opportunities. *Her expectation was that staff perform hand hygiene at the appropriate times such as those listed in the following hand hygiene policy.	F 880		

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F 880	Continued From page 11 Review of Sanford Policy "Hand Hygiene and Handwashing-Rehab/Skilled, Senior Living," last reviewed/revised on 4/6/21, revealed: *During Patient Care "1. Wash hands with plain soap and water or with anti-microbial soap and water: a. If hands are visibly soiled. b. If hands are visibly contaminated with blood or bodily fluids. 2. If hands are not visibly soiled or contaminated with blood or bodily fluids, use an alcohol-based hand rub (ABHR) for routinely cleaning hands: a. Before having direct contact with residents, patients, and children. b. After having contact with another person's skin. 2. Observation on 5/3/22 at 5:16 p.m. in the south neighborhood revealed CNAs G and H went to four different resident rooms without performing hand hygiene or using an ABHR before they had physical contact with each of the residents in those rooms to assist them to the dining area for the evening meal. Observation on 5/3/22 at 6:21 p.m. revealed CNA H did not perform hand hygiene between assisting each resident to eat; she was standing and walked from resident to resident seated around the tables in the south neighborhood dining area as she assisted each resident take a bite of food or drink some beverage. Interview on 5/5/22 at 10:34 a.m. with DON B confirmed CNAs G and H failed to follow proper procedures for hand hygiene.	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
	43A098	A. BUILDING _____ B. WING _____	05/05/2022

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

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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 from 5/3/22 through 5/5/22. Sanford Care Center Vermillion was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Veronica Schmidt
TITLE: administrator
(X6) DATE: 5/24/22

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
	43A098	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/03/2022

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

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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 5/3/22. Sanford Care Center Vermillion 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 the deficiency identified at K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 918 SS=E	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. 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	K 918	K918 1.The Plant Operations (PO) Manager educated PO staff to check batteries weekly on each generator on 5/3/22. 2. The Plant Operations manager posted a checklist by each generator for PO staff to document the weekly battery checks with date and their initials on 5/18/22. 3. The Plant Operations Manager will audit the checklists weekly for one month and then monthly for 2 months to ensure the battery tests are being done and documented weekly. The Plant Operations Manager will report any variances to the Improvement Advisor. The Improvement Advisor will report the audit findings to the quarterly CC/AL QAPI Committee meeting to determine ongoing monitoring and interventions.	5/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Schmidt — TITLE: administrator — (X6) DATE: 5/24/22

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
	43A098	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/03/2022

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

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K 918	Continued From page 1 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 document generator battery conductivity monthly (no documentation for 2021 and 2022). Findings include: 1. Record review on 5/3/22 at 2:45 p.m. revealed there was no documentation of the battery conductivity in the monthly maintenance logs for the generator for the calendar years 2021 and 2022. Interview with the facilities supervisor and facilities manager at 2:45 p.m. on 5/3/22 revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. They stated they were unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.	K 918		

South Dakota Department of Health

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	10697	A. BUILDING: _____ B. WING _____	05/05/2022

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

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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 5/3/22 through 5/5/22. Sanford Care Center Vermillion was found not in compliance with the following requirements: S253 and S301.	S 000		
S 253	44:73:04:14 Memory Care Units Each facility with memory care units shall comply with the following provisions: (1) Each physician's, physician assistant's, or nurse practitioner's order for confinement that includes medical symptoms that warrant seclusion or placement shall be documented in the resident's chart and shall be reviewed periodically by the physician, physician assistant, or nurse practitioner; (2) Therapeutic programming shall be provided and shall be documented in the overall plan of care; (3) Confinement may not be used as a punishment or for the convenience of the staff; (4) Confinement and its necessity shall be based on a comprehensive assessment of the resident's physical and cognitive and psychosocial needs, and the risks and benefits of this confinement shall be communicated to the resident's family; (5) Locked doors shall conform to Sections: 18.2.2.2 and 19.2.2.2 of NFPA 101 Life Safety Code, 2012 edition; and (6) Staff assigned to the memory care unit shall have specific training regarding the unique needs of residents in that unit. At least one caregiver shall be on duty on the memory care unit at all times. This Administrative Rule of South Dakota is not met as evidenced by:	S 253	S253 1. Social Worker O showed surveyor signed paper order for resident 21 to be admitted to SCU but it did lack signs and symptoms for unit. Social Worker will obtain updated order with signs and symptoms by 6/2 and include in resident's chart. 2. Social worker O will complete audit of residents in SCU by 6/2/22 to ensure admit orders included signs and symptoms for unit; if any missing Social Worker O will follow up by initiating new order with signs and symptoms to be signed by physician. 3. Social Worker O created admit order sheet for SCU for physician and families to sign by 6/2/22 that will be used for all future admits which includes section for documenting signs and symptoms for admission to unit. 4. Social Worker O and/or designee will audit all new admits to SCU for completed form to include signed order by physician and signs and symptoms for admission to unit weekly x2; every other week x2 and then monthly x2 and will report findings to weekly IDT meeting and quarterly to QAPI committee who will determine any ongoing monitoring and interventions.	6/2/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vanessa Schmidt — TITLE: Administrator — (X6) DATE: 5/24/22

South Dakota Department of Health

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S 253	Continued From page 1 Based on observation, interview, record review, and policy review, the provider failed to ensure one of nine residents (14) residing in the provider's special care unit (SCU) had physician's orders for placement in the secured unit. Findings include: 1. Observation on 5/4/22 at 8:48 a.m. revealed resident 14 resided in the SCU. Review of resident 14's medical record revealed: *He was admitted on 4/27/20 to the SCU. *A physician order dated 4/24/20 stated, "Admit to: (intermediate)" *No signed physician's order for placement in the SCU, which would have included the medical symptoms for such placement. Interview on 5/4/22 at 11:44 a.m. with certified social worker O revealed the admission process for the SCU included needing a physician's order of placement. Review of the provider's 11/13/21 Policy "Screening And Admission To Special Care Unit" revealed "A physician's examination and orders for placement in a secured unit will be obtained prior to admission."	S 253		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition	S 301	S301 1.On 5/19/22, the Nutrition Services manager got a hold of all 5 staff that had not completed their annual nutrition in-service to let them know they had to get this education completed by 5/29/22. 2. All 19 Nutrition services staff were audited at the time of the survey to determine if the annual education had been completed. For new staff, the Nutrition Services manager will mark her calendar 30 days after their hire to ensure they have completed it and remind them at hire they have 30 days to complete it.	

South Dakota Department of Health

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S 301	Continued From page 2 and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and review of training records, the provider failed to ensure 5 of 19 nutrition services employees (Q, R, S, T, and U) had completed the required annual training on nine of nine topics including: *Food safety. *Handwashing. *Food handling and preparation techniques. *Foodborne illnesses. *Serving and distribution procedures. *Leftover food handling policies. *Time and temperature controls for food preparation and service. *Nutrition and hydration. *Sanitation requirements. Findings include: 1. Review of the nutrition services "Annual Required In-service Training Record" for the past year (2021-2022) revealed: *A nutrition services staff name was listed on each line of the report. *Columns for each of the nine topics listed above. *Instructions included entering the date of completion for each topic. *All the rows contained checkmarks for each of the nine required topics except for the rows of employees Q, R, S, T, and U, which contained no checkmarks. Interview on 5/5/22 at 1:40 p.m. with registered dietitian W confirmed the five nutrition services employees (Q, R, S, T, and U) had not completed the required annual training.	S 301	3. In future, the dietitian, will provide the annual nutrition in-service by January 31st of each calendar year for all current nutrition services staff to ensure they receive it. For new staff, the Nutrition Services manager will mark her calendar 30 days after their hire to ensure they have completed it and remind them at hire they have 30 days to complete it. 4. The Nutrition Services Manager will report to the Improvement Advisor when the 5 staff have completed their annual in-service education. The dietitian will audit 100% of new staff 30 days after hire to ensure they are getting their training done for the next 3 months and report findings to IDT weekly and quarterly to QAPI committee who will determine ongoing compliance. The dietitian will also report to the February QAPI meeting each year staff compliance with the annual training in-service and the QAPI committee will determine any ongoing ongoing monitoring and interventions.	5/30/22

South Dakota Department of Health

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S 000	Continued From page 3	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 5/3/22 through 5/5/22. Sanford Care Center Vermillion was found in compliance.	S 000		