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	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Chamberlain Care Center	300 S Byron Blvd Chamberlain, SD 57325

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review the provider failed to ensure one of one sampled resident (1) had neurological checks completed after a fall. Findings include: 51472 1. Review of the provider's submitted SD DOH FRI regarding resident 1 revealed: *On 12/8/24 at 1:41 p.m. resident 1 was found on the floor beside his bed. *He stated that he was trying to get up into his wheelchair. *On 12/9/24 resident 1 complained of back pain and staff documented confusion and lethargy (decreased consciousness, fatigue, drowsiness, or sleepiness). *On 12/9/24 resident 1 was sent to the clinic for an appointment due to the inability to collect a urine sample. -At the clinic appointment he was diagnosed with three rib fractures, a urinary tract infection (UTI), and dehydration. Observation and interview on 12/26/24 at 3:50 p.m. with resident 1 revealed: *He was self-propelling in his wheelchair rapidly. *He fell at least once per week, sometimes every other day. *He had to be careful because he was unsteady. *He explained that he had been told by staff to use his call light to get assistance, but he only used his call light when he wanted to go outside to smoke. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on [DATE]. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A073	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/27/2024
NAME OF PROVIDER OR SUPPLIER: Sanford Chamberlain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 300 S Byron Blvd Chamberlain, SD 57325	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*His 11/15/24 Brief Interview of Mental Status (BIMS) assessment score was 3 which indicated he was severely cognitively impaired. *His diagnoses included: Tourette's (a disorder involving repetitive movements or unwanted sounds) retention of urine, weakness, urinary tract infection, dehydration, and prostate cancer. *He was found on the floor in his room on 11/20/24, 12/1/24, and 12/8/24. *The documented assessments following each of those falls indicated that he denied hitting his head or having pain. Review of the neurological flow sheet from resident 1's 12/8/24 fall revealed: *The neurological flow sheet indicated that neurological checks were to be completed every 15 minutes x4 [four times], every 1 hour x2 [two times] , every 2 hours x2, and every 4 hours x2 *The neurological checks were not documented as completed on the day shift on 12/9/24 and 12/10/24 or the night shift on 12/9/24. Review of the provider's 3/1/24 Fall Prevention & Follow-Up Reporting-LTC policy revealed: *For any resident with a fall the resident will have vital signs taken each shift for 3 days. *In the event of an unwitnessed fall, open the post fall order set in Matrix for: Fall: With Suspected head trauma- Neuro checks Q [every]15 minutes x 4, then Q1 hour x2, then Q2 hours x2, then Q4 hours x2, then Q shift x3. This order set will apply to all unwitnessed falls regardless of signs of head trauma.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, observation, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (2) who fell , suffered head trauma, and required emergency room treatment, while attempting to sit down on a whirlpool chair when one of one sampled employee (K) failed to ensure the brakes on the whirlpool tub chair were locked. Findings include: 1. Review of the provider's 12/17/24 FRI regarding resident 2 revealed: *She was getting ready to take a bath in the whirlpool tub. *She attempted to sit down on the tub chair. *The tub chair brakes were not locked, and she fell forward landing on her face. -She had supraorbital bruises to both eyes, a skin tear to her right wrist, and she was transferred to the emergency room (ER) for evaluation. Interview and observation on 12/26/24 at 3:05 p.m. with resident 2 revealed: *She stated I look like this is [because] the aide didn't lock brakes on [the] chair. Maybe try: She was going to take a whirlpool bath and when she went to sit down on the tub chair, it slid out from under her, and her face hit the floor. *Her face had purple bruising under both eyes, a greenish-colored raised area above her right eye, and a scabbed area between her eyes on the bridge of her nose. *She now ensured the brakes are locked on the tub chair before attempting to sit down. *She was not willing to share the staff member's name of who did not lock the brakes. -She stated She is a sweet thing and I do not want anything to happen to her. -She indicated she felt the issue was related to lack of staff training rather than an intentional oversight. Interview on 12/27/24 at 8:22 a.m. with licensed practical nurse (LPN) I revealed a certified nursing assistant assisted residents with baths unless the CNA was not of age to operate mechanical equipment. Observation and interview on 12/27/24 at 8:29 a.m. with CNA J in the tub room revealed: (continued on next page)

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	43A073	A. Building B. Wing	12/27/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	*She received education on the use of the whirlpool tub chair in 9/2024 when she took classes to become a CNA. *She knew the wheels on the tub chair needed to be locked to prevent it from sliding when a resident attempted to sit in it. *She indicated there were various signs throughout the tub room with the safety requirements needed to operate and clean the tub appropriately. -No signage indicated the wheels needed to be locked on the tub chair. -She had no knowledge of where the manufacturer's instructions for the operation of the tub chair would have been located. Observation on 12/27/24 at 8:38 a.m. of the whirlpool tub room revealed: *There was a whirlpool tub chair which had four wheels. -The two wheels on the back of the chair were able to be locked to prevent the chair from moving. -All the wheels were functioning as intended. Review of resident 2's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *Her diagnoses included: arthritis, stroke, history of fall with fracture, and epilepsy. *Review of resident 2's 12/27/24 care plan revealed: *She was identified to be at risk for falls related to a stroke that affected her left side. -Her medications listed on the care plan included: use of antipsychotic, narcotic, antidepressant, antihypertensive, antihistamines, and laxative meds [medications] which can contribute to falls. -She was independent in room and throughout facility with front wheeled walker for stability. -Her bathing performance required Supervision of one staff member for transfer to/from bath. *Review of her nurses progress notes revealed: -On 12/17/24 she was sent to the ER due to a fall from a tub chair that did not have the wheel brakes locked. -On 12/26/24 she still has bruising to the face and some on her arms. Review of resident 2's ER notes revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Sanford Chamberlain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 300 S Byron Blvd Chamberlain, SD 57325	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*She was seen on 12/17/24 at 8:05 a.m. for a fall. -She had a skin tear to her right wrist, a skin tear to her right nose, and a hematoma (raised bruised area) above her right eye. -A CAT scan was performed and was negative for any acute intracranial findings. -She was discharged back to the facility on [DATE] at 10:05 a.m. with orders to Ice for next 24-48 hours. Review of CNA K's employment record and training records revealed: *She was hired on 10/29/24. *Her last day of orientation was on 12/14/24. *Her 11/13/24 Safe Resident Handling Equipment Competency Validation Checklist included: -Uses appropriate safety measures and equipment to prevent accidents. -Manufacturer's directions should be followed for use of bathing equipment. *On 12/17/24 following the above incident CNA K was provided immediate education by LPN I to remember to lock the brakes on beds, wheelchairs, and bath chairs. Interview on 12/27/24 at 12:30 p.m. with director of nursing (DON) A, social worker B, and administrative assistant D regarding the use of the tub chair revealed: *DON A stated a staff member could ask management for the manufacturer's instructions for safe use of the tub chair, if they wanted to look at it. *After the above incident with the tub chair, staff had been educated by writing a note on the communication sheet. Review of the provider's 12/15/24 Communication Sheet revealed a handwritten note that read All staff education *make sure breaks are locked on shower/bath chairs. *There was no documentation to support nursing staff had read the form. Review of the provider's 9/3/24 Bathing policy revealed: *Use appropriate safety measures and equipment to prevent accidents. *Manufacturer's directions for operating and maintaining equipment should be followed. Review of the 10/1/09 Manufacturer's Patient Transfer Lift System Safe Operation and Daily Maintenance Instructions revealed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	*System Preparation (Before Transferring or Lifting). -Lock the brakes by stepping down on the lock-arm tab located on the back of the rear casters. -WARNING --Failure to lock the caster brakes before the resident is transferred, could result in injury to the operator or patient [resident]. Review of the provider's 8/1/23 Safe Resident Handling Program (SRHP) revealed: *Will include bathing equipment as part of the SRHP. Locations may choose a separate manufacturer for bathing equipment (tub lifts, shower chairs, shower gurney) but must consider safety, training and compliance. *Will provide training and documented competency for all caregivers (including contracted employees with direct care responsibilities) prior to providing resident care with mobility and bathing. Review of the provider's 11/20/24 Nursing Assistant, Certified, job description revealed, Assists the resident in transferring, repositioning, and walking using correct and appropriate transfer techniques and equipment .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), observation, interview, record review, and policy the provider failed to ensure one of one sampled resident (1) consumed adequate fluid intake to alleviate and prevent dehydration. Findings include: 51472 Based on the South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and policy review the provider failed to ensure one of one sampled resident (1) consumed adequate fluid intake to prevent dehydration and one of one sampled resident (1) had neurological checks completed after a fall. Findings include: 1. Review of the provider's submitted SD DOH FRI regarding resident 1 revealed: *On 12/8/24 at 1:41 p.m. resident 1 was found on the floor beside his bed. *He stated that he was trying to get up into his wheelchair. *On 12/9/24 resident 1 complained of back pain and staff documented confusion and lethargy (decreased consciousness, fatigue, drowsiness, or sleepiness). *On 12/9/24 resident 1 was sent to the clinic for an appointment due to the inability to collect a urine sample. -At the clinic appointment he was diagnosed with three rib fractures, a urinary tract infection (UTI), and dehydration. -Resident 1 received intravenous (through a vein) fluids and an antibiotic. *On 12/9/24 returned to facility with orders to start oral antibiotics on 12/10/24 and follow up with the provider on 12/11/24. Observation on 12/26/24 at 3:00 p.m. of the water pitchers in the residents' rooms revealed: *There were pitchers with a clear liquid in the residents' rooms. *Some pitchers were full, and others were partially full. *Some pitchers contained ice and others did not. *Resident 1's water pitcher was in his room and was full of a clear liquid with ice present. Interview on 12/26/24 at 3:20 p.m. with certified nursing assistant (CNA) G revealed: *Water was passed out to the resident rooms around 2:00 p.m. (continued on next page)

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	43A073	A. Building B. Wing	12/27/2024

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F 0692 Level of Harm - Actual harm Residents Affected - Few	*Resident 1 was able to request a refill of water. *Resident 1 often requested staff refill his water. *With meals resident 1 usually drinks coffee, juice, and water. *Dietary staff documented the residents' fluid and food intake at meals. *Nursing staff did not document fluids taken by residents outside of meals unless the resident was on a fluid restriction. Interview on 12/26/24 at 3:30 p.m. with licensed practical nurse (LPN) I revealed: *Water was to be passed out to the resident rooms at 2:00 a.m. and 2:00 p.m. *LPN I was the nurse on duty on 12/8/24 at the time of resident 1's fall. *Resident 1 did not describe to her how the fall happened, but LPN I stated that resident 1 was unsteady and fell . * She stated that resident 1 had been more unsteady and she was unsure how he had not fallen more than he had. *She stated that resident 1 wants to be more independent than he is safe to be, and he did not follow recommendations made by staff. *She reported that at the time of resident 1's fall, he denied pain. *She explained that his right rib pain documented after the fall was also documented before the fall. *She stated that there was a urine sample ordered before his clinic appointment on 12/9/24 but it was unable to be obtained due to incontinence. Observation and interview on 12/26/24 at 3:50 p.m. with resident 1 revealed: *He was self-propelling in his wheelchair rapidly. *He had no trouble getting water. *He could get water out of his sink or go get a pop. *His gave a urine sample about four days ago that was pure yellow. *His urine was not usually that yellow. *He fell at least once per week, sometimes every other day. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	*He had to be careful because he was unsteady. *He explained that he had been told by staff to use his call light to get assistance, but he only used his call light when he wanted to go outside to smoke. Review of resident 1's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *His 11/15/24 Brief Interview of Mental Status (BIMS) assessment score was 3 which indicated he was severely cognitively impaired. *His diagnoses included: Tourette's (a disorder involving repetitive movements or unwanted sounds) retention of urine, weakness, urinary tract infection, dehydration, and prostate cancer. *He was found on the floor in his room on 11/20/24, 12/1/24, and 12/8/24. *The documented assessments following each of those falls indicated that he denied hitting his head or having pain. *On 11/19/24 resident 1 was started on an antibiotic for a sore throat. *On 11/19/24 and 11/20/24 it was documented that he had spent most of the time in his bed. *On 11/19/24 and 11/21/24 it was documented that he had no appetite and a small appetite. *On 11/22/24 Resident 1 reported he had left rib pain and staff documented he had increased weakness and needed for assistance with cares. -He stated that he fell into his w/c [wheelchair] yesterday. -An order was received to x-ray his left ribs. *On 11/28/24 resident 1 refused his supper. *On 12/3/24 resident 1 reported he had right rib pain. *On 12/3/24 at 5:02 p.m., it was documented that resident 1 had remained in his room since breakfast. *On 12/4/24 it was documented that resident 1 was asking if he was in the right room and he stated that he was seeing a dog outside. *On 12/4/24 resident 1 went to a clinic appointment, medication changes included: -Discontinue melaxicam, flexiril, and januvia. -start hydrocodone three times a day and continue the as needed order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-start Excedrine ES two tablets in the morning as needed. -Omeprazole 20 mg (milligrams) in the morning. -Naproxyn 500mg at bedtime. -Update in a week on how he [resident 1] responds in one week. *On 12/6/24 resident 1's daughter was informed that his status has declined. *On 12/8/24 resident 1 needed assistance with changing his brief and clothing. *On 12/9/24 resident 1 had episodes of confusion, increased lethargy, and c/o [complaints of] back pain. -He was scheduled for an appointment at the clinic. -He was diagnosed with right rib fractures, dehydration, and a urinary tract infection. *On 12/11/24 labs were rechecked and the antibiotic he was taking by mouth was increased. *On 12/12/24 the clinic called and asked that we push water and fluids for resident 1 as his labs showed he was still slightly dehydrated. Review of resident 1's fluid intake for meals from 12/1/24 through 12/26/24 revealed: *There was no documentation for 18 of 26 breakfasts. *There were three suppers and one lunch that were not documented on. *There were 12 times that 0ml (milliliters) of fluid was documented. *According to the fluid intake documentation, resident 1's average daily fluid intake: -Between 12/1/24 and 12/7/24 it was 557 ml. -Between 12/8/24 and 12/14/24 it was 480 ml. -Between 12/15/25 and 12/21/24 it was 640 ml. -Between 12/22/24 and 12/26/24 it was 980 ml. Review of resident 1's weights from 12/3/24 through 12/24/24 revealed: *On 12/3/24 resident 1 weighed 156 pounds. *On 12/11/24 resident 1 weighed 138 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	*On 12/18/24 resident 1 weighed 147.5 pounds. *On 12/24/24 resident 1 weighed 152 pounds. Review Resident 1's 11/19/24 dietary quarterly assessment progress note entered by supervisor, nutrition and food services C revealed: *Resident 1's meal intakes were, breakfast is 76-100%, lunch is mostly 76-100%, and dinner is 50-100%. *His fluid intakes are good and his weights have been steady over the past 6 months. Review of Resident 1's 12/9/24 clinic note revealed: *He had been a little confused and unsteady for the past week or so. *He had some chronic right rib pain. * He had a history of urinary frequency and has a known history of prostate cancer. *He was alert and aware of surroundings but has some slurred speech. -*The right rib fractures were new from 11/22/2024. *His labs indicated that resident 1 was dehydrated and had a significant UTI. *He was dehydrated appearing. *IV fluids and an IV antibiotic were ordered with a plan to start antibiotics by mouth. Review of resident 1's 12/27/24 care plan revealed: *He was at risk of falling. *He had a history of noncompliance with physical therapy recommendations and not calling for help when needed. *He had an identified history of urinary tract infections that was initiated on 8/15/22. -The approach for this indicated staff were to Report signs of UTI (acute confusion, urgency, frequency, bladder spasms, nocturia, burning, pain, difficulty urinating, low back pain/flank pain, malaise, nausea/vomiting, chills, fever, foul odor concentrated urine, blood in urine). * He had an identified potential for nutrition and fluid problems that was initiated on 7/1/22. -The goal was that resident 1 will be well hydrated. -The approaches to achieve this goal included: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	--Resident 1 will have all meal and fluid intakes recorded daily. --Resident 1 will have fresh water in his room and is capable of drinking on his own. He will be reminded to drink plenty of fluids. --Resident 1 will be weighed weekly with his bath and an increase or decrease of 4# [pounds] or more will be reported to the charge nurse and re-weights will be done according to policy. Interview on 12/27/24 at 8:42 a.m. with cook H revealed: *Resident 1 usually comes out for all meals. *If he would would choose to remain in his room for a meal a meal tray would be provided. *She stated that in her observations, if resident 1 received a meal tray in his room he ate the majority of the meal. *If she noticed a resident's meal intake had decreased, she would notify a nurse or CNA. Interview on 12/27/24 at 8:45 a.m. and 10:40 a.m. with registered nurse (RN) F revealed: *Nursing does not document fluid intake for residents. *Resident 1 usually comes out to the dining room for breakfast. *There was no formal process to alert nursing if there was a decrease in a resident's intake. *She stated that she would expect dietary or a CNA to report to the charge nurse if a decrease in meal intake was seen. *She stated that if there was an identified change in a resident's intake this would be passed on through report (nurse to nurse communication at change of shift). *Supervisor, nutrition and food services C would bring the resident weights printout to nursing weekly. *If there was an increase or decrease of four pounds in a resident's weight from the previous week the resident would be reweighed daily for three days. *She confirmed resident 1 weighed 138 pounds on 12/11/24. *She confirmed this weight was more than a four-pound weight loss from the week prior. *She confirmed there were no daily weights completed after the weight loss was documented. Interview on 12/27/24 at 10:45 a.m. with supervisor, nutrition and food services C revealed: *She printed a weekly weight report on Fridays around noon. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	*She identified on that report, with a marking, any weight gains, or losses greater than four pounds. *She would give the report to the CNA coordinator, the director of nursing, the minimum data set (MDS) nurse, and the charge nurse for each hallway. *The dietician completed audits on resident intakes. *She audited quarterly when she completes the MDS. *It was her expectation that resident intakes for all meals were to be charted. *She stated that she completed random audits of meal documentation and reports them to quality. *She stated she had not noticed missing documentation. Interview on 12/27/24 at 12:15 p.m. with director of nursing A revealed: *It was her expectation that a neurological check would be completed on every shift for 72 hours with all falls. *Resident weights were to be completed on Mondays, Tuesdays, and Wednesdays. *On Friday, the supervisor, nutrition and food services C printed the weight report, highlighted residents with weight changes and gave it to the DON, MDS coordinator, the CNA coordinator, and the charge nurse for each hallway. *She expected if there was a weight change, the resident who had the weight change would be reweighed for three days. *She indicated that the charge nurse was responsible for initiating the reweights. *The CNA coordinator was responsible for follow-up on the reweights. *The dietician and the MDS coordinator would then be notified if there was a confirmed weight loss unless it was a planned weight loss. *She stated that the resident's representative should be notified of a confirmed weight loss. *She stated that the resident's provider would be notified of a confirmed weight loss if an order for a nutritional supplement was needed. *She stated that the nursing staff did not chart fluid intake unless the resident was on a fluid restriction. *She stated that any fluid consumed during snacks or in the resident's room was not documented. Review of the provider's 4/1/24 Nutrition and Hydration- Food and Nutrition policy revealed: (continued on next page)

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	12/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Chamberlain Care Center	300 S Byron Blvd Chamberlain, SD 57325

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	*Identify, implement, monitor and modify interventions (as appropriate) that are consistent with the resident's assessed needs, choices, preferences, goals, and current professional standards of practice to maintain acceptable parameters of nutritional status. *Monitor weight and intake of food and drinks. *Monitor to determine whether the resident is consuming adequate food and fluid for their needs. Fluid includes beverages, foods that are liquid at room temperature and fluid in foods. *A goal of 1,500 mls (ccs) of liquids per day is often recommended. Fluids at snack times will be recorded in PCC-POC [EMR] per care plan. Review of the provider's 10/15/24 Weight and Height policy revealed: *The location will immediately inform the resident, consult with the resident's physician and, if known, notify the resident's legal representative when there is a significant change in the resident's weight, as defined by the RAI [Resident Assessment Instrument] manual. *If weight varies by more than three percent, reweigh resident and document. *The licensed nurse should notify the director of food and nutrition (DFN) within 24 hours regarding any significant weight change. Significant weight change is defined as five percent in 30 days, 7.5 percent in 90 days and 10 percent in 180 days.