

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/16/2026
NAME OF PROVIDER OR SUPPLIER Sanford Chamberlain Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure a medication error rate of less than 5 percent related to resident (36) no receiving her full dose of insulin, resident (38) not receiving her calcium/vitamin D/vitamin K due to incorrect labeling, residents (24 and 37) self-administering a medication with no assessment or orders from the physician. Those observed errors resulted in a medication error rate of 14.29%. Findings include: 1. Observation on 7/15/26 at 11:30 a.m. certified medication assistant (CMA) N left Seroquel (an antipsychotic medication) (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), 50 mg, 1 tab in a medicine cup on resident 24's bedside table to the left of her bed and did not watch her take the medication. 2. Observation on 7/15/26 at 11:33 a.m. CMA N put Ipratropium-Albuterol 0.5 milligrams (mg)-3mg/3 milliliter (mL) 1 vial liquid nebulizer medication into the nebulizer machine for resident 37 and then left the room after the machine was turned on by resident 37. 3. Review of resident 24's electronic medical record (EMR) indicated she admitted to the facility on [DATE]. Her 7/3/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. Her medication administration record (MAR) indicated she had a physician's order dated 6/25/24 for Seroquel 50 mg, 1 tab by mouth once a day at 12:00 p.m. There were no special instructions noted on this order to indicate that this medication was to be self-administered. Her diagnoses include anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder (PTSD) (is a mental health condition that can develop after a person experiences or witnesses a traumatic event), epilepsy (is a chronic brain disorder characterized by two or more unprovoked seizures that are sudden bursts of abnormal electrical activity in the brain that can cause temporary changes in behavior, muscle control, awareness, or sensations), weakness, and chronic pain. She had a physician's order dated 10/13/25 that indicated that resident 24 may self-administer Triamcinolone Acetonide Cream (TAC) (a topical corticosteroid used to treat skin inflammation and itching), Lidocaine cream, TUCKS pads (pre-moistened medicated cooling pads relieves irritation, itching, burning and swelling), Estradiol cream (a prescription topical estrogen used to treat vaginal and genitourinary symptoms caused by low estrogen levels), Nystatin powder (a topical antifungal medication used to treat skin and mucous membrane infections caused by yeast), and Flonase (a corticosteroid that reduces inflammation in the nasal passages). Her 4/23/26 self-administration of medication assessment indicated the list of medications the resident would like to self-administer included TAC cream, Lidocaine cream, TUCKS pads, Estradiol cream, Nystatin powder, and Flonase. In this assessment, resident 24 voiced that she did not want to administer pill forms as she might spill, drop, or mess up. She had some difficulties with the use of her left arm d/t ROM limitations and a weak hand grip. 4. Review of resident 37's EMR indicated he admitted to the (continued on next page)		

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.

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

TITLE

(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. His 6/12/26 BIMS assessment score was 15, which indicated his cognition was intact. His MAR indicated a physician's order dated 5/11/2026 for Ipratropium-Albuterol solution for nebulization 0.5 mg-3 mg/ 3 ml, 1 unit dose inhaled 5 times per day. There were no special instructions on this order to indicate that this medication was to be self-administered. His diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), hemiplegia affecting right dominant side (paralysis affecting one side of the body), presbyopia (loss of near vision), emphysema (a chronic lung condition and a form of COPD caused by gradual damage to the alveoli, the tiny air sacs responsible for gas exchange), dysphagia (difficulty swallowing, which may involve trouble getting food or liquids from your mouth to stomach), and aphasia (a language disorder that affects the ability to speak, understand, read, or write). He had a physician's order dated 9/29/2015 that indicated resident 37 may self-administer Refresh Optive eye drops. He had a physician's order dated 10/7/2015 that indicated her may self-administer ProAir Hydrofluoroalkane (HFA) inhaler (a pressurized canister that contains medication mixed with liquid HFA, a propellant used in modern metered-dose inhalers). 5. Observation on 7/15/26 at 12:03 p.m. of registered nurse (RN) J administering Novolog FlexPen (insulin aspart, a rapid-acting insulin in a prefilled pen. A needle attaches to the pen for medication administration) to resident 36. The ordered dose was 5 units (u). RN J injected the insulin into the resident's abdomen by pressing the medication dial at the end of the FlexPen. One second was counted from the start of the administration (when the pen is placed against the resident's stomach and the metered dose dial is pressed down) to the time the insulin pen was removed. She removed the pen from the resident's abdomen prior to the medication being fully dispensed into the resident's abdomen, as evidenced by when she pulled the insulin pen away from the resident; the insulin then expelled out of the needle onto the resident's skin. 6. Review of resident 36's electronic medical record (EMR) indicated she admitted to the facility on [DATE]. Her 5/29/26 BIMS assessment score was 10, which indicated her cognition was moderately impaired. Her MAR indicated a 4/15/24 physician's order for Novolog FlexPen U-100 Insulin (insulin aspart U-100) 100unit/3mL, give 5 units subcutaneously with meals at 8:30 a.m., 12:00 p.m., and 5:30 p.m. Her diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar that causes damage to multiple peripheral nerves, usually leading to pain, numbness, or tingling in the hands and feet), chronic kidney disease stage 3 (moderate kidney damage indicating reduced kidney function), hypo-osmolality (low concentration of particles in the blood, usually from having too much water compared to electrolytes), and hyponatremia (sodium levels are low in the blood), chronic systolic (congestive) heart failure (a long-term condition where the heart's left ventricle weakens and can't pump blood effectively, leading to fluid buildup in the body), rheumatic mitral stenosis (a narrowing of the mitral valve caused by rheumatic fever, which restricts blood flow from the left atrium to the left ventricle and can lead to breathing difficulty and fatigue), nonrheumatic mitral insufficiency (also called mitral regurgitation, is when the mitral valve doesn't close properly allowing blood to leak backward from the left ventricle into the left atrium), and pulmonary hypertension (high blood pressure in the arteries that carry blood from the right side of the heart into the lungs, usually caused by narrowed or blocked lung vessels). 7. Interview on 7/15/26 at 3:16 p.m. with CMA N revealed that she did not usually leave medications with residents, but if she did, then they should have a self-administer order. She did not know how to tell if a resident had a self-administer order on the MAR or if there was another place to look. If she did not know what to do, she looked at the previous worker's documentation to see what she should do. 8. Interview on 7/15/26 at 4:28 p.m. with RN J revealed her process for insulin administration was that she would wait three seconds before removing the insulin pen from the resident to ensure the resident receives the full (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do so safely. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to self-administer medications(s). 3. The interdisciplinary team will also determine where medications will be stored. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self-administering. 5. The interdisciplinary team will determine who will document the medication administration.18. Review of the provider's reviewed 3/30/26 Medication: Administration Including Scheduling and Medication Aides revealed The resident has the right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Procedure: Follow the Six Rights: right medication, right dose, right resident, right route, and right documentation. Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication.		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure that evaluations for self-administration of medication were completed for two of two residents (24 and 37) whose medications were left at the bedside by CMA N. Findings include: 1. Observation on 7/15/26 at 11:30 a.m. certified medication assistant (CMA) N left Seroquel (an antipsychotic medication) (a drug that alters neurotransmitter activity in the brain to reduce symptoms of mental health conditions), 50 mg, 1 tab in a medicine cup on resident 24's bedside table to the left of her bed and did not watch her take the medication. 2. Observation on 7/15/26 at 11:33 a.m. CMA N put Ipratropium-Albuterol 0.5 milligrams (mg)-3mg/3 milliliter (mL) 1 vial liquid nebulizer medication into the nebulizer machine for resident 37 and then left the room after the machine was turned on by resident 37. 3. Review of resident 24's electronic medical record (EMR) indicated she admitted to the facility on [DATE]. bHer 7/3/26 Brief Interview for Mental Status (BIMS) assessment score was 14, which indicated her cognition was intact. Her medication administration record (MAR) indicated she had a physician's order dated 6/25/24 for Seroquel 50 mg, 1 tab by mouth once a day at 12:00 p.m. There were no special instructions noted on this order to indicate that this medication was to be self-administered. Her diagnoses include anxiety (anticipation of future danger or misfortune with feelings of distress and/or sadness and symptoms such as restlessness or irritability), post-traumatic stress disorder (PTSD) (is a mental health condition that can develop after a person experiences or witnesses a traumatic event), epilepsy (is a chronic brain disorder characterized by two or more unprovoked seizures that are sudden bursts of abnormal electrical activity in the brain that can cause temporary changes in behavior, muscle control, awareness, or sensations), weakness, and chronic pain. She had a physician's order dated 10/13/25 that indicated that resident 24 may self-administer Triamcinolone Acetonide Cream (TAC) (a topical corticosteroid used to treat skin inflammation and itching), Lidocaine cream, TUCKS pads (pre-moistened medicated cooling pads relieves irritation, itching, burning and swelling), Estradiol cream (a prescription topical estrogen used to treat vaginal and genitourinary symptoms caused by low estrogen levels), Nystatin powder (a topical antifungal medication used to treat skin and mucous membrane infections caused by yeast), and Flonase (a corticosteroid that reduces inflammation in the nasal passages). Her 4/23/26 self-administration of medication assessment indicated the list of medications the resident would like to self-administer included TAC cream, Lidocaine cream, TUCKS pads, Estradiol cream, Nystatin powder, and Flonase. In this assessment, resident 24 voiced that she did not want to administer pill forms as she might spill, drop, or mess up. She had some difficulties with the use of her left arm d/t ROM limitations and a weak hand grip. 4. Review of resident 37's EMR indicated he admitted to the facility on [DATE]. His 6/12/26 BIMS assessment score was 15, which indicated his cognition was intact. His MAR indicated a physician's order dated 5/11/2026 for Ipratropium-Albuterol solution for nebulization 0.5 mg-3 mg/ 3 ml, 1 unit dose inhaled 5 times per day. There were no special instructions on this order to indicate that this medication was to be self-administered. His diagnoses included chronic obstructive pulmonary disease (COPD) (a group of lung diseases that block airflow and make it difficult to breathe), hemiplegia affecting right dominant side (paralysis affecting one side of the body), presbyopia (loss of near vision), emphysema (a chronic lung condition and a form of COPD caused by gradual damage to the alveoli, the tiny air sacs responsible for gas exchange), dysphagia (difficulty swallowing, which may involve trouble getting food or liquids from your mouth to stomach), and aphasia (a language disorder that affects the ability to speak, understand, read, or (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	write).He had a physician's order dated 9/29/2015 that indicated resident 37 may self-administer Refresh Optive eye drops. He had a physician's order dated 10/7/2015 that indicated her may self-administer ProAir Hydrofluoroalkane (HFA) inhaler (a pressurized canister that contains medication mixed with liquid HFA, a propellant used in modern metered-dose inhalers).5. Interview on 7/15/26 at 3:16 p.m. with CMA N revealed that she did not usually leave medications with residents, but if she did, then they should have a self-administer order. She did not know how to tell if a resident had a self-administer order on the MAR or if there was another place to look. If she did not know what to do, she looked at the previous worker's documentation to see what she should do.6. Interview on 7/16/26 at 1:21 p.m. with the DON B revealed she expected the residents to have a self-administration assessment completed by the minimum data set (MDS) coordinator V and an order from the residents' primary care provider before leaving the medications with the residents to self-administer. The orders for self-administration for the CMA's and nurses to see would be listed under the special instructions under each medication. DON B confirmed that residents 24 and 37 did not have self-medication administration orders for the observed Seroquel and Ipratropium-Albuterol nebulizer medications. She expected that the staff would stay with the residents until the medication was taken completely. 7. Review of the provider's reviewed 10/31/25 Resident Self-Administration of Medication policy revealed Purpose to determine if the resident can safely self-administer medications. To identify which medications may be safely self-administered. Procedure: 1. Complete the resident self-administration of medications UDA to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process. The interdisciplinary team must determine whether each resident who expresses a desire to self-administer medications can do so safely. 2. The interdisciplinary team will determine if the resident has any specific educational needs or if he or she requires any accommodation to self-administer medications(s). 3. The interdisciplinary team will also determine where medications will be stored. 4. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left within reach of another resident and must be under the control of the resident who is self-administering. 5. The interdisciplinary team will determine who will document the medication administration.8. Review of the provider's reviewed 3/30/26 Medication: Administration Including Scheduling and Medication Aides revealed The resident has the right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Procedure: Follow the Six Rights: right medication, right dose, right resident, right route, and right documentation. Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe, and just before administering the medication. Do not leave medication at the bedside or at the table unless there is a specific physician order to do so, and the resident has been evaluated for self-administration.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to maintain resident bathrooms in a clean and well-kept manner, free from damage to flooring, for one of one sampled resident (28). Findings include: 1. Observation on 7/14/26 at 8:46 a.m. in resident 28's bathroom revealed a gouge in the flooring near the wall, measuring approximately 12 inches long by one inch wide. The flooring curled up around the edges of the gouge causing an uneven surface. 2. Interview on 7/16/26 at 9:27 a.m. with interim administrator A revealed that she expected the staff to notify the director of nursing or maintenance staff of any damaged flooring in resident rooms. She considered torn bathroom flooring to be a fall hazard for both the residents and the staff, which made it a priority to repair. 3. Interview on 7/16/26 at 9:37 a.m. with director of nursing (DON) B revealed that she considered the torn flooring to be a fall hazard and an uncleanable surface (an area heavily damaged or corroded that traps bacteria in its crevices and cannot be adequately sanitized). She said repair of items that pose a safety hazard should be fixed right away. 4. Interview on 7/16/26 at 9:07 a.m. with plant operations supervisor (POS) F revealed that he did not know the flooring was torn in resident 28's bathroom. He agreed the torn flooring was an uncleanable surface and a fall hazard. He expected the housekeeping staff to notify him as they encountered such situations during daily bathroom cleaning. Any staff member could request maintenance repairs by submitting a Microsoft Teams ticket, paging or calling him, or leaving him a handwritten note. POS F said the maintenance staff address repair requests as time allows, and resident room repairs are typically completed after a resident moves out of the room, before a new resident moves in. Urgent room repairs could be completed when residents were at an activity or a medical appointment, or the resident could temporarily relocate to a different room to avoid disruption of their routine. 5. Interview on 7/16/26 at 9:47 a.m. with certified nursing assistant (CNA) I revealed that she did not know the flooring was torn in resident 28's bathroom. She agreed it was a fall hazard that should have been reported to the maintenance team. We could catch a lift [a mechanical device used to assist residents during transfers to the toilet or a wheelchair] on it, or the resident could catch their foot on it and fall. 6. Review of resident 28's electronic medical record (EMR) revealed she admitted to the facility on [DATE]. She had a diagnosis of unspecified dementia (a group of symptoms affecting memory, thinking, and social abilities) and a 5/1/26 Brief Interview for Mental Status (BIMS) assessment score of three, indicating she had severe cognitive impairment. Resident 28's 5/8/26 care plan indicated she relied on assistance from two staff members to transfer to and from the toilet, bed, recliner, wheelchair, and bath chair. She used her feet to independently propel herself in her wheelchair but required staff assistance to travel longer distances. Her care plan revealed she had a history of falling and that the staff should keep her environment free of clutter. 7. Review of the provider's current Assets Resource Packet revealed that assets (capital and physical properties used for facility operations and resident care, categorized as land improvements, buildings, and fixed or movable equipment) should be repaired or replaced if their condition did not meet code or safety standards.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the provider failed to ensure two of two sampled residents (2 and 22) had a Preadmission Screening and Resident Review (PASRR) II completed. Findings Include: 1. Review of resident 22's electronic medical record (EMR) revealed she was admitted to the facility on [DATE]. Her diagnoses included bipolar disorder, post-traumatic stress disorder (PTSD) and depression. Her [DATE] Brief Interview for Mental Status (BIMS) assessment score was 14 which indicated she was cognitively intact. She had a Department of Social Services (DSS) letter dated [DATE] which indicated she had been approved for 365 days for admission or continued stay to a nursing facility effective as of the date of this letter. At that time, you may be appropriate for discharge to a lower level of care. As a result of the review, the following recommendations are made: Initiate mental health services-this may include psychiatric medication management and supportive therapy. A PASRR resident review was completed for resident 22 by licensed social worker (LSW) U on [DATE] for the facility on the screening form it was noted the end date of current PASRR was [DATE]. The screening indicated resident 22 had serious mental illness of bipolar disorder, PTSD, and depression. She was referred to Maximus (a clinical service that evaluates individuals applying for or residing in Medicaid-certified nursing facilities) on [DATE] at 10:36 a.m. for resident review. Maximus notice dated [DATE] to LSW U indicated resident 22 PASRR Level I Review determination had expired. The letter stated the Level I screen expired because your health care professional did not complete the Level I screening form and/or submit requested documentation within the required timeframe. 2. Interview on [DATE] at 2:00 p.m. with LSW U revealed she completed the PASRR paperwork for the facility. She had received the PASRR expiration letter for resident 22 and had submitted a PASRR Level I review on [DATE]. Resident 22 was referred to Maximus on [DATE] for a Level II review and she never received papers back from Maximus. Typically, Maximus sends the determination Level II letter to the facility (or to her) after the required information is sent to Maximus. 3. Follow-up interview on [DATE] at 7:48 a.m. with LSW U revealed she had heard back from Maximus and they want her to resubmit the Level I paperwork for resident 22 again. She is unsure why they did not receive the paperwork for resident 22 in 2024. She had not followed up on the letter. 4. Interview on [DATE] at 9:56 a.m. with director of nursing (DON) B revealed she would expect LSW U to complete and submit the PASRR Level I forms and resident reviews and take care of any recommendations made for the residents. 5. Review of resident 2's EMR revealed she admitted to the facility on [DATE]. Her [DATE] BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included mild neurocognitive disorder due to known physiological condition with (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behavioral disturbances (a noticeable decline in cognitive abilities such as memory, attention, or problem-solving), psychotic disorder (a serious mental health condition characterized by a significant loss of contact with reality), unspecified disorder of adult personality and behavior (a mental health condition marked by enduring, inflexible patterns of thinking, feeling, and behaving that significantly deviate from cultural norms, cause distress or impair daily functioning), unspecified intellectual disabilities (significant limitations in intellectual functioning). She had a Department of Human Services (DHS) letter dated [DATE], which indicated she had been approved for continued staff-provided services by the facility for 120 days, effective [DATE]. As a result of the review, the following recommendations were made: Please continue with skilled therapy services and/or restorative nursing services as appropriate. It is also recommended to obtain a psychological evaluation with a full-scale IQ and adaptive testing to assist in determining the most appropriate services to meet your needs. 6. Resident 2's PASRR level II paperwork was requested by the survey team on [DATE] at 10:11 a.m. 7. Interview on [DATE] at 1:56 p.m. with LSW U revealed that she did not submit the PASRR level II until it was requested by the survey team on [DATE]. She was not sure why it was not submitted before this date but said it should have been completed before the approved days expired. 8. Review of the provider's [DATE] Preadmission Screening and Resident Review (PASRR) policy revealed It is the policy to screen all potential admissions on an individual basis. As part of the preadmission process, [NAME] Care Center and Swing Bed will participate in the Preadmission Screening and Resident Review (PASRR) screening process (prescreening and Level I) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability (ID) or related condition. Based upon the Level I screen, [NAME] Care Center and Swing Bed will not admit an individual with a mental disorder or intellectual disability until the Level II screening process has been completed and the recommendations allow for a nursing facility admission and [NAME] Care Center and Swing Bed's ability to provide the specialized services determined in the Level II screen process, the facility will coordinate with the South Dakota State ASA Nurse Consultant related to the individual needs of the resident as indicated. Annually and with any significant change of status, [NAME] Care Center and Swing Bed will complete the PASRR Level I screen for those individuals identified per the Level II screen requiring specialized services. The facility will report any changes as identified via the screen to the state mental health authority or state intellectual disability authority promptly.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interview, and policy review the provider failed to ensure resident care plans had been revised to reflect their current needs for two of six sampled residents (2, and 30). Findings include: 1. Observation on 7/14/26 from 9:52 a.m. to 2:32 p.m., resident 2 was asleep in bed. 2. Observation on 7/14/26 at 2:14 p.m. resident 30 was in his wheelchair outside smoking a cigarette on the sidewalk, near the street, alone. 3. Review of resident 30's electronic medical record (EMR) revealed he was admitted on [DATE]. His 5/15/26 Brief Interview for Mental Status (BIMS) assessment score was 10 indicating he had moderately impaired cognition. He had diagnoses of cerebral palsy (a neurological disorder that permanently affects a person's ability to move, maintain balance, and sustain posture), chronic pain, and anxiety disorder. He had a smoking assessment completed on 4/13/26, which indicated he was able to wheel himself out to the designated smoking area. He could safely light his own cigarette and smoke the entirety of the cigarette without causing injury to himself. He was able to put out the cigarette and dispose of the cigarette butt in the designated trash can. His care plan did not indicate he was a smoker, or that a smoking assessment had been completed, or that he was safe to smoke independently. 4. Interview on 7/14/26 at 2:32 p.m. with certified nursing assistant (CNA) I regarding resident 2 revealed that she refused breakfast and lunch. She slept in during the day and will wake up in the evening. 5. Observation on 7/14/26 at 4:24 p.m., resident 2 was waking up but still lying in bed in the dark. 6. Review of resident 2's EMR revealed she admitted to the facility on [DATE]. Her 6/19/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbances (a noticeable decline in cognitive abilities such as memory, attention, or problem-solving), psychotic disorder (a serious mental health condition characterized by a significant loss of contact with reality), unspecified disorder of adult personality and behavior (a mental health condition marked by enduring, inflexible patterns of thinking, feeling, and behaving that significantly deviate from cultural norms, cause distress or impair daily functioning), unspecified intellectual disabilities (significant limitations in intellectual functioning), depression, non-infective gastroenteritis and colitis (inflammation of the stomach, intestines, or colon that is not caused by an infection), and gastric ulcer without hemorrhage or perforation (an open sore on the stomach lining). Her 4/16/24 physician diet orders were for dysphagia (difficulty or discomfort in swallowing) diet, soft with thin liquids. There was a general nursing order on 3/10/26 to give 1 cup of coffee with (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morning medications in the room before getting the resident up for the day. Notify dietary aide to get breakfast ready after medications were given to anticipate her needs. There were no further supplemental dietary orders input into the physician order report. Her 6/26/26 care conference documentation indicated that licensed social worker (LSW) U, long-term care (LTC) activities G, minimum data set (MDS) coordinator V, and resident 2's power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) were in attendance. They reviewed her diet and her weight loss and discussed options to see about getting the resident to gain weight, as she refused her supplements and was becoming more picky with what she eats. Resident 2's POA said she could bring resident 2 some snacks and have nursing regulate it more so resident 2 does not eat them all in one sitting. MDS coordinator V will talk with the dietician about a 'peanut butter cup' therapy to see if that might help some. The staff will continue to monitor her diet/weights. Her 6/26/26 care plan indicated that resident 2 needed increased encouragement from the staff to get up and come out for meals. She was weighed weekly during her bath, and any increase or decrease of 4 lbs. would be reported to the charge nurse. Re-weights would be performed according to policy. Staff was to notify the provider of significant weight changes. Diet as ordered was a regular diet, International Dysphagia Diet Standardization Initiative (IDDSI) 6 soft and bite-sized, with tray set up as needed (prn). She was to be offered small to routine size portions at mealtimes. Staff were to ask her if she wanted second helpings. The second helpings offered were to be small portions. Fluid consistency was thin, but with a 2000 milliliter (mL) per day fluid restriction. Resident 2's care plan did not include information about offering supplements such as magic cup or peanut butter cup therapy, as indicated by care conference and dietary notes. It did not include interventions on how staff should encourage her to take part in mealtimes. Her care plan did not indicate a dysphagia diet as per the physician's order. Her 6/30/26 nutritional risk progress notes indicated that the resident has been refusing her chocolate coffee (chocolate Ensure in coffee); she was offered Magic Cups ice cream supplement at the noon meal. Staff reports that resident 2's acceptance of this supplement is variable and inconsistent. 7. Observation on 7/15/26 at 12:15 p.m. registered nurse (RN) J revealed that she woke resident 2 up for her medications and asked her if she wanted lunch. Resident 2 refused lunch. No additional supplements were offered at that time. There was no encouragement to attend lunch. 8. Observation on 7/15/26 at 12:42 p.m. of resident 30 was in his wheelchair outside smoking a cigarette on the sidewalk, near the street, alone. 9. Interview on 7/16/26 at 9:23 a.m. with minimum data set (MDS) coordinator V revealed care plans should be updated with changes as they occur, significant changes or MDS quarterly assessments. When asked if smoking would be on a resident care plan, she stated It depends on the resident, if we feel like they are safe to independently she would not put it on the care plan. Staff are updated on who can smoke by the smoking list. She would add it to the care plan if a resident needed certain (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	safety precautions. 10. Interview on 7/16/26 at 10:01 a.m. with director of nursing (DON) B revealed she expects smoking to be on a resident care plan. Along with the smoking assessment information and any precautions needed for the resident would be on the resident's care plan. 11. Interview on 7/16/26 at 1:21 p.m. with DON B revealed that she would expect the care plan to include interventions for the staff to try to encourage resident 2 to get up to attend meals. She would also expect the care plan to include the supplements the staff should be giving her. She said the supplements were also on the medication administration record (MAR) or treatment administration record (TAR) so the nurses knew to give them to the residents. 12. Review of the provider's 12/1/25 Care Plan policy revealed: Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and policy review, the provider failed to ensure that two of two sampled residents (21 and 37) on oxygen had their tubing changed weekly. Findings include: 1. Observation on [DATE] at 9:20 a.m. revealed resident 21's oxygen tubing was dated [DATE]. Observation on [DATE] his oxygen tubing was dated [DATE]. 2. Observation on [DATE] at 9:34 a.m. revealed resident 37's oxygen tubing was dated [DATE]. Observation on [DATE] his oxygen tubing was dated [DATE] for the following Monday. 3. Observation and interview on [DATE] at 1:10 p.m. with Registered Nurse (RN) J regarding the dates on the resident's oxygen tubing revealed that resident 21 and 37's oxygen tubing were dated [DATE], which was the date it would expire and need to be changed. She stated the oxygen tubing should be changed weekly and dated at that time, not the date it expired. 4. Review of the electronic medical records for resident 37 indicated that the oxygen tubing had been changed weekly, but the dates on the tubing did not coincide with those records. Resident 21 did not have a physician's medical order to administer oxygen. 5. Interview on [DATE] at 2:36 p.m. with director of nursing (DON) B regarding resident weekly oxygen tubing change and dating revealed she expected the tubing to be changed weekly and dated at that time. 6. Review of the provider's [DATE] oxygen administration policy revealed that oxygen administration is carried out only with a medical provider order. The disposable equipment should be changed weekly or according to the manufacturer's instructions and marked with date and initials.		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to notify the physician of one of two sampled residents (2) who had unplanned significant weight loss (a loss of 5% (percent) of body weight in 30 days, 7.5% in 90 days, or 10% in 180 days). Findings include: 1. Observation on 7/14/26 from 9:52 a.m. to 2:32 p.m., resident 2 was asleep in bed. 2. Interview on 7/14/26 at 2:32 p.m. with certified nursing assistant (CNA) I revealed that she refused breakfast and lunch that day. Resident 2 typically slept in during the day and will wake up in the evening. She slept in during the day and will wake up in the evening. 3. Observation on 7/14/26 at 4:24 p.m., resident 2 was waking up but still lying in bed in the dark. 4. Review of resident 2's EMR revealed she admitted to the facility on [DATE]. Her 6/19/26 BIMS assessment score was 0, which indicated her cognition was severely impaired. Her diagnoses included mild neurocognitive disorder due to known physiological condition with behavioral disturbances (a noticeable decline in cognitive abilities such as memory, attention, or problem-solving), psychotic disorder (a serious mental health condition characterized by a significant loss of contact with reality), unspecified disorder of adult personality and behavior (a mental health condition marked by enduring, inflexible patterns of thinking, feeling, and behaving that significantly deviate from cultural norms, cause distress or impair daily functioning), unspecified intellectual disabilities (significant limitations in intellectual functioning), depression, non-infective gastroenteritis and colitis (inflammation of the stomach, intestines, or colon that is not caused by an infection), and gastric ulcer without hemorrhage or perforation (an open sore on the stomach lining). Her weight on 7/12/26 was 121 lbs. Her weight on 4/12/26 was 134.5 lbs. This was a 10.04% weight loss in 90 days. Her weight on 7/12/26 was 121 lbs., and on 1/12/26 was 138.5 pounds (lbs.). This is a 12.64% weight loss in 180 days. Her documented weight on 5/17/26 was 127 lbs. This was a weight loss of 4 lbs. since the documented weight of 131 lbs. on 5/13/26. Her weight on 5/10/26 was 124.5 lbs., and her weight on 4/27/26 was 137 lbs., showing a weight loss of 12.5 lbs. Her weight on 2/11/26 was 130 lbs., on 2/10/26 135.5 lbs., and on 2/9/26 131.5 lbs., indicating weight variances of 4 or more lbs. Her 4/16/24 physician diet orders are for dysphagia (difficulty or discomfort in swallowing) diet, soft foods and with thin liquids. Her 6/26/26 care conference documentation indicated that licensed social worker (LSW) U, long-term care (LTC) activities G, minimum data set (MDS) coordinator V, and resident 2's power of attorney (POA) (someone designated on a legal document to act on behalf of a resident) were in attendance. They reviewed her diet and her weight loss and discussed options to see about getting the resident to gain weight, as she refused her supplements and was becoming more picky with what she eats. Resident 2's POA said she could bring resident 2 some snacks and have nursing regulate it more so resident 2 does not eat them all in one sitting. MDS coordinator V will talk with the dietician about a 'peanut butter cup' therapy to see if that might help some. The staff will continue to monitor her diet/weights. Her 6/30/26 nutritional risk progress notes indicated that the resident has been refusing her chocolate coffee (chocolate Ensure in coffee); she is being offered Magic Cups ice cream supplement at the noon meal. Staff reports that the resident's acceptance of this supplement is variable and inconsistent. 5. Observation on 7/15/26 at 12:15 p.m. registered nurse (RN) J revealed that she woke resident 2 up for her medications and asked her if she wanted lunch. Resident 2 refused lunch. 6. On 7/15/26 at 2:45 p.m., a request was made for documentation to resident 2's physician about weight variances. No documentation was received. 7. Interview on 7/16/26 at 1:21 p.m. with director of nursing (DON) B revealed that residents' weights were checked weekly, and if they have a 4 lb. difference, then the nursing staff would notify (continued on next page)		

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a physician. If the weight is a significant loss, then the provider is notified by being seen directly in the clinic or, if more urgent, in the emergency room (ER).8. Review of the provider's reviewed 9/30/25 Weight and Height policy revealed purpose to ensure that the resident maintains acceptable parameters of nutritional status regarding weight. To report changes in a resident's clinical condition (significant weight change) to physician and family and/or resident. To accurately measure weight and height. To monitor weight loss or gain in a resident. Weight procedure: 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.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure residents were free from significant medication errors for one of one sampled resident (36), who was not administered his physician-ordered dose of insulin by registered nurse (RN) J, which increased his risk for having diabetic complications, including hyperglycemia (an abnormally high blood sugar level). Additionally, resident 38 did not receive his calcium/vitamin D3/vitamin K medication from certified medication assistant (CMA) H because the label on the medication did not match the medication. Findings Include: 1. Observation on 7/15/26 at 12:03 p.m. of registered nurse (RN) J administering Novolog FlexPen (insulin aspart, a rapid-acting insulin in a prefilled pen. A needle attaches to the pen for medication administration) to resident 36. The ordered dose was 5 units (u). RN J injected the insulin into the resident's abdomen by pressing the medication dial at the end of the FlexPen. One second was counted from the start of the administration (when the pen is placed against the resident's stomach and the metered dose dial is pressed down) to the time the insulin pen was removed. She removed the pen from the resident's abdomen prior to the medication being fully dispensed into the resident's abdomen, as evidenced by when she pulled the insulin pen away from the resident; the insulin then expelled out of the needle onto the resident's skin. 2. Review of resident 36's electronic medical record (EMR) indicated she admitted to the facility on [DATE]. Her 5/29/26 BIMS assessment score was 10, which indicated her cognition was moderately impaired. Her MAR indicated a 4/15/24 physician's order for Novolog FlexPen U-100 Insulin (insulin aspart U-100) 100unit/3mL, give 5 units subcutaneously with meals at 8:30 a.m., 12:00 p.m., and 5:30 p.m. Her diagnoses included type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar that causes damage to multiple peripheral nerves, usually leading to pain, numbness, or tingling in the hands and feet), chronic kidney disease stage 3 (moderate kidney damage indicating reduced kidney function), hypo-osmolality (low concentration of particles in the blood, usually from having too much water compared to electrolytes), and hyponatremia (sodium levels are low in the blood), chronic systolic (congestive) heart failure (a long-term condition where the heart's left ventricle weakens and can't pump blood effectively, leading to fluid buildup in the body), rheumatic mitral stenosis (a narrowing of the mitral valve caused by rheumatic fever, which restricts blood flow from the left atrium to the left ventricle and can lead to breathing difficulty and fatigue), nonrheumatic mitral insufficiency (also called mitral regurgitation, is when the mitral valve doesn't close properly allowing blood to leak backward from the left ventricle into the left atrium), and pulmonary hypertension (high blood pressure in the arteries that carry blood from the right side of the heart into the lungs, usually caused by narrowed or blocked lung vessels). 3. Interview on 7/15/26 at 4:28 p.m. with RN J revealed her process for insulin administration was that she would wait three seconds before removing the insulin pen from the resident to ensure the resident receives the full dose. She agreed that if the insulin was expelled onto the resident's skin when removing the needle from the injection site, the resident did not get her full ordered dose. RN J stated that if the resident did not get her full dose, she would tell the director of nursing (DON), monitor the patient, and notify the provider. 4. Observation on 7/16/26 at 7:42 a.m. of CMA H during medication pass for resident 38 revealed two medication blister packs (a card with medications sealed in individual plastic bubbles) for the morning dose for LDR Vit C600+D3/MINS CHEW 60 EACH. Generic for LDR VIT C600+D3/MINS CHEW CENTURY, each containing one-half tab. CMA H prepared to give the morning dose by removing each half tab from the medication blister packs into a separate paper cup. 5. Interview and EMR review on 7/16/26 at 7:50 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m. with CMA H revealed a physician's order for Calcium 500 milligram (mg)-Vitamin D3 1000 u - Vitamin K 40 micrograms (mcg) chewable tablet 1 tab twice a day. CMA H acknowledged that the medication blister pack label and the physicians' orders in the EMR did not match. CMA H stated that she did not know the process for reporting that type of error, but I can tell the nurse or the DON. When we complete the medication card changeover to the new packs, the staff are supposed to double-check they match the MAR and previous cards.6. Interview on 7/16/26 at 7:56 a.m. with DON B revealed that she expected the medication cards would match the physicians' order on the MAR.7. Review of resident 38's EMR indicated she admitted to the facility on [DATE]. Her 4/17/26 BIMS assessment score was 12, which indicated her cognition was moderately impaired. Her diagnoses included weakness, age-related osteoporosis (a condition where bones become thin, weak, and more likely to break easily) without current pathological fracture, and chronic kidney disease stage 3 moderate kidney damage (indicating reduced kidney function).8. Interview on 7/16/26 at 1:21 p.m. with the DON B revealed that a resident not receiving their full ordered dose of insulin, the resident's physician not being notified, and the lack of increased monitoring for resident 36 after the medication error were considered a significant medication error.9. Interview on 7/16/26 at 3:15 p.m. with DON B revealed that the label on the medication blister pack was incorrect for resident 38's calcium/vitamin D/vitamin K order. She expected the medication to have the correct label on it.10. Observation on 7/16/26 at 3:25 p.m. the medication blister packs for resident 38's calcium/vitamin D/vitamin K order were still in the medication cart.11. Review of the provider's reviewed 3/2/26 Medication Errors policy revealed the location will have medication error rates of five percent or less and those residents are free of significant medication errors. When a medication error occurs, it will be reported promptly to the attending physician, resident, and or responsible party and documented in the SAFE Event Reporting application. Definitions from the State Operations Manual Significant Medication Error one which causes the resident discomfort or jeopardizes his or her health and safety. Wrong Dose/Amount when the resident receives an amount of medication that is greater than or less than amount ordered by the prescriber.12. Review of the provider's reviewed 3/30/26 Medication: Administration Including Scheduling and Medication Aides revealed The resident has the right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Procedure: Follow the Six Rights: right medication, right dose, right resident, right route, and right documentation. Perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medication.		

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 07/16/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, document review, and policy review, the provider failed to ensure appropriate hand hygiene was performed by one of one observed cook (Q) to meet professional food cleanliness standards. Findings include: 1. Observation of the noon meal on 7/14/26 at 12:13 p.m. revealed cook Q plating meals for the residents in the [NAME] Hall dining room. She stood between a serving table that held the residents' meal tickets and trays and a counter that held steam pans containing polish sausage, sauerkraut, and peas. A bag of hot dog buns sat on the counter near the steam pans. A sink, a box of gloves, and a trash can were next to the counter. Beside the serving table stood a rack of dessert bowls containing pears and potato salad. [NAME] Q was wearing gloves and a hairnet. At 12:22 p.m., cook Q used her left gloved hand to pick up a plate and her right gloved hand to take a hot dog bun from the bag and place it on the plate. She picked up a serving tong with her right hand and placed sausage on the bun, then used a different serving scoop to place sauerkraut on the plate, and a third scoop to place peas on the plate. Each utensil was returned to its steam pan after use. She then used her right hand to retrieve bowls of potato salad and pears from the rack, placing them on the plate she held in her left hand. At 12:24 p.m., wearing those same gloves, she set the plate on the serving table, left the serving line, walked across the dining room to the kitchenette area, opened the refrigerator door, retrieved a bottle of ketchup and a bottle of mustard, set them on the adjacent counter, and closed the refrigerator door. Carrying the ketchup in one hand and the mustard in the other, she walked back to the serving line, set the mustard bottle on the serving table, opened the ketchup bottle and used both hands to squeeze ketchup onto the sausage on the plate she had prepared. She set the ketchup bottle on the serving table, picked up the mustard bottle, opened it, used both hands to squeeze mustard onto the sausage, and set the mustard bottle on the serving table. She picked up the plate and gave it to certified nursing assistant (CNA) L, who took the plate to one of the residents. [NAME] Q removed her gloves, put them in a trash can near the sink, and put on a new pair of gloves without washing her hands. At 12:25 p.m., cook Q began to repeat the plating process. She held a plate with her left gloved hand and used her right gloved hand to retrieve a hot dog bun out of its bag, then access serving tongs and scoops to plate the sausage, sauerkraut, and peas. She retrieved bowls of potato salad and pears from the rack, placed them on the plate, and asked CNA L to put ketchup and mustard on the sausage, saying, I can't because I have gloves on. CNA L did so and took the plate to one of the residents. [NAME] Q picked up another plate, retrieved a hot dog bun out of its bag, and repeated the plating process. After handing the third plate to CNA L, cook Q picked up a pen with her right hand and wrote on a piece of paper by the residents' meal tickets while resting her left hand on the serving table. She set the pen down and turned back to the serving counter, picked up a plate, and used the tongs to retrieve a sausage. She used the serving tongs to hold the sausage in place while cutting it up with a pizza cutter, then plated the sauerkraut and peas before handing the plate to CNA M, who delivered it to one of the residents in the dining room. Between 12:30 p.m. and 12:33 p.m., cook Q prepared three more plates, retrieving the hot dog buns with her right gloved hand. Each time she handed a plate to CNAs L and M, cook Q rested her left hand on the serving table while using her right hand to write on a resident meal ticket. At 12:34 p.m., with those same gloved hands, cook Q reached above the serving counter, opened a cupboard door, retrieved a napkin, and closed the cupboard door. She placed the napkin on a meal tray which contained a plate of food, picked up the tray with both hands, and handed the tray to CNA L. She (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued preparing plates without changing gloves or performing hand hygiene. At 12:38 p.m., wearing those same gloves, cook Q picked up a glass covered with saran wrap, removed the saran wrap, picked up the glass with her fingers surrounding the rim of the glass, and set the glass on a meal tray. She resumed the plating process, and after handing the plate to CNA L, she rested her left hand on the serving table and wrote on meal tickets with her right hand. At 12:40 p.m., with the same gloved hands, cook Q reached above the serving counter, opened a cupboard door, retrieved a meal tray, closed the cupboard door, and set the tray on the serving table. She placed silverware on the tray and prepared a plate with sausage, sauerkraut, and peas, then placed a plate cover on the plate and handed the tray to CNA L, who delivered the tray to a resident room. [NAME] Q then write on a meal ticket and resumed the plating process. At 12:43 p.m., cook Q pulled the serving tong and scoops out of the steam pans and placed them all on a single plate to take to the sink. She asked the residents in the dining room if they wanted anything else, and one resident asked for another sausage. [NAME] Q retrieved a hot dog bun from its bag with her right hand, put it on a plate, used the serving tong from the plate of dirty utensils to place sausage on the bun, put the tong back onto the plate of dirty utensils, and walked the plate over to a resident. She returned to the serving counter and loaded all the dishes onto a cart, which she took through the dining area to the kitchenette sink. She removed her gloves at 12:48 p.m. as CNA M told her a resident wanted another sausage. [NAME] Q walked over to the cart where she had placed the steam pans, put a glove on her right hand, picked up a plate and used her right gloved hand to retrieve a sausage from the steam pan. She told CNA M, The tongs are all dirty. This is acceptable, isn't it? That's what we do in the kitchen, and laughed. At 12:50 p.m. she left the kitchenette to take the cart of dirty dishes back to the main kitchen. 2. Interview on 7/15/26 at 11:05 a.m. with dietary manager T revealed that she expected her staff to change gloves and perform hand hygiene between each task. She should not pick up a bun with gloved hands if she is also using those hands to pick up serving utensils and open refrigerator or cupboard doors. 3. Observation on 7/16/26 at 7:44 a.m. in the kitchenette revealed cook Q frying eggs for residents eating breakfast in the [NAME] Hall dining room. [NAME] Q was wearing gloves and a hairnet. She walked away from the stove, opened the refrigerator door, retrieved a bowl of eggs, closed the refrigerator door, and set the bowl of eggs on the counter next to the stove. She walked through the dining room to the serving counter, opened a cupboard and retrieved a bowl, closed the cupboard, and took the bowl back to the stove area. She cracked two eggs into the pan on the stove, removed her gloves, put them in a trash can, and put on a new pair of gloves without performing hand hygiene. [NAME] Q then dispensed water from the coffee machine into two bowls and put them in the microwave to heat up the water. After setting the microwave timer, she placed her left gloved hand on the counter and her right gloved hand on the edge of the stovetop. When the microwave timer sounded, cook Q removed the bowls and placed them on a serving tray, made toast by handling the bread with her gloved hands, and took a tray of juice glasses out of the refrigerator. She put everything on the serving cart and rolled it through the dining room to the serving table. She opened cupboard drawers to retrieve silverware and individual containers of jelly. She used a spoon to stir oatmeal into the two bowls of hot water, put everything on individual meal trays and served the trays to the residents sitting at the dining room table. She retrieved silverware and another bowl from the cupboard, picked up a container of milk from the serving table, poured milk into the bowl, added oatmeal, stirred it, and served the bowl to a resident at the dining table. Wearing those same gloves, cook Q repeated the process for another bowl of oatmeal, dispensing water from the coffee machine and heating it in the microwave, resting her gloved hands on the counter and stove handle while she waited for the microwave to sound. She retrieved a new gallon of milk from the refrigerator, poured (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	milk into a glass, put the milk back in the refrigerator, and carried the bowl of hot water and the glass of milk with her fingers surrounding the rim. She placed both items on a tray on top of a serving cart, took a spoon from a drawer and stirred oatmeal into the bowl, then wheeled the cart over to a resident at the dining table. She took the glass of milk off the tray with her fingers around the rim of the glass and set it on the resident's table. [NAME] Q continued moving between the dining room and the kitchenette, opening cupboards to retrieve dishes, napkins, and silverware, which she added to a tray on the serving cart. At 7:57 a.m. she left the kitchenette and wheeled the cart and a meal tray to a resident's room. She knocked on the door, announced herself, took the tray into the room, then wheeled the cart back to the kitchenette area. She removed her gloves, put them in the trash, washed her hands, retrieved a can of pop from the refrigerator and took it to one of the residents in the dining room. She proceeded to serve coffee to the residents and take dirty dishes to the kitchenette sink without wearing gloves or washing her hands. 4. Observation on 7/16/26 at 8:15 a.m. in the [NAME] Hall dining room revealed cook Q at the serving counter, opening a cupboard to restock individual containers of cream cheese and jelly. She was wearing gloves. At 8:17 a.m. she closed the cupboard door, removed her gloves, and put them in the trash. She did not perform hand hygiene. 5. Interview on 7/16/26 at 8:20 a.m. with cook Q revealed that she usually works in the main kitchen and was filling in for a dietary aide who was on vacation. I haven't worked in this dining room for a while. She said she wears gloves most of the time because she has a cyst on her finger that recently ruptured. She said that when wearing gloves, I make sure I don't touch the food. As long as I don't touch the food, then I don't have to change my gloves. 6. Review of the provider's personnel file training documentation revealed that cook Q completed hand hygiene training and glove use education on 4/5/21, and repeated hand hygiene training on 8/25/25. She also successfully passed a hand hygiene and food temperature competency assessment on 5/26/26. 7. Review of the provider's 7/14/26 Hand Washing and Glove Use-Food Nutrition Services policy revealed that staff were to use uncontaminated, disposable gloves for single tasks, and to wash hands when switching tasks and after performing any activity that could contaminate hands. The policy read, Employees involved in food preparation, distribution and serving must consistently utilize good hygienic practices and techniques, and that employees do not need to wear gloves when distributing food to residents at the dining table unless they have a cut or sore, which should then be double covered with a bandage and a glove. The policy revealed that employees should use proper utensils and single-use gloves for food handling to reduce the risk of cross-contamination. Hand washing should occur after touching any contaminated object including dirty utensils and dirty dishes, before and after using gloves, and between dirty and clean dish handling. Gloves should be changed before handling ready-to-eat foods, any time contamination is suspected, when touching a doorknob or faucet, and when coming in contact with something that may have been contaminated such as pots, pans, trays, and utensils. 8. Review of the provider's 12/26/24 Care Center Safe Meal Service, LTC policy revealed that when plating and delivering resident meals, food service staff should pay attention to potential contamination during delivery and complete proper hand washing or glove change if needed.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and policy review, the provider failed to ensure that 1 of 1 sampled resident 17 had his call light in reach on 7/14/26, 7/15/26, and 7/16/26 after he returned from therapeutic leave. Findings include: 1. Observation on 7/14/26 at 9:00 a.m. revealed resident 17 in his room in his bed. There was no call light within reach. There was no call light plugged into the wall outlet. Resident 17 stated he was there to recuperate from drinking and from fractures to both of his hips. He stated he could get up and walk around. He stated he did not need a call light. 2. Observations on 7/15/26 at 9:15 a.m. and 7/16/26 at 12:49 p.m. revealed resident 17 was not in his room and there was no call light plugged into the wall outlet near his bed. 3. Observation and interview on 7/16/26 at 12:50 p.m. with certified medication assistant (CMA) H revealed that resident 17's room did not have a call light plugged into the wall near his bed. She stated he had been on therapeutic leave from 7/10/26 to 7/13/26, and his room had been updated with new flooring. She stated his room had been cleared out, but items were brought back into the room, and his call light near the bed was not plugged back into the wall. She stated resident 17 had returned from his leave on 7/13/26 and acknowledged he must not have had a call light since he returned to the facility that day. 4. Interview on 7/16/26 at 1:15 p.m. with registered nurse (RN) J revealed she was not aware that resident 17 had not had his call light in reach since returning from his leave on 7/13/26. She acknowledged that residents should have a call light in reach for assistance at all times. 5. Review of the provider's 7/8/25 call light policy revealed that residents always had a method of calling for assistance.		