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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A098	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sanford Care Center Vermillion	125 S Walker Street Vermillion, SD 57069

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), interview, employee file review, and policy review, the provider failed to protect one of one sampled resident (3) from verbal abuse who had profanity verbalized toward her by certified nursing assistant (CNA) H.Findings include:1. Review of the 1/12/2026 SD DOH FRI report revealed:*A report was made on 1/12/26 involving [resident 4] who expressed concerns of verbal abuse by a staff member [CNA H] to another resident [resident 3].*CNA H was interviewed by director of nursing (DON) A and clinical care leader (CCL) F on 1/12/26 and then sent home and remained on suspension pending the investigation.*Resident 3's date of admission to the facility was on 12/2/25.*Resident 3's most recent Brief Interview for Mental Status (BIMS) assessment score was 3 indicating severe cognitive impairment.*Resident 3 had pertinent diagnoses of dementia, hearing loss, chronic kidney disease stage 3.*Resident 4's date of her admission to the facility was on 2/1/24.*Resident 4's most recent BIMS assessment score was 15 indicating she is cognitively intact.*Resident 4 had pertinent diagnoses of left leg above knee amputation, depression, and post-traumatic stress disorder.*It was reported, On the evening of 1/11/26 [Resident 4] heard [Resident 3] in the hallway saying I need it now repeating it a couple of times. [Resident 3] is known to be impatient and rude to staff.*[Resident 4] reports she overheard CNA H respond, [Resident 3] shut the [expletive] up.*[Resident 4] stated she then wheeled herself to the hallway and confirmed it was CNA H who had said this to resident 3.*When resident 3 was interviewed the next day by social worker (SW) I, she did not remember the incident and reported she was feeling okay.*CNA H was given education on disruptive conduct and behaviors and online education for customer service.*CNA H was allowed to return to work after completion of education and disciplinary action.*Audits were to be conducted weekly by director of nursing (DON) A or designee for three months which include interviews with three staff CNA H had worked with that week and three residents that he has cared for that week.*CNA K was interviewed on 1/13/26 at 3:00 p.m. by CCL F regarding the evening of 1/11/26 revealed:-When CNA K returned from her break at 5:00 p.m. CNA H was in a bad mood. She said CNA H seemed irritated and overwhelmed; she was unsure what had happened to put him in this mood.-She believed that was why he left early.-CNA H was being rude to her during that shift.-She had completed most of resident 3's cares that evening.-Resident 3 was no more demanding than usual that evening.-CNA K had seen CNA H get irritated before, but not swear at anyone. 2. Interview on 1/27/26 at 9:22 a.m. with resident 3 revealed:*She did not know the date or what day it was.*She said she was feeling fine.*When asked if staff had yelled at her she stated, I don't think so.*When asked how staff treat her, she stated okay. 3. Interview on 1/27/26 at 9:30 a.m. with resident 4 regarding the 1/11/26 incident revealed:*Resident 3 repeats things often and uses her call light often.*She had been sitting in her room on 1/11/26 across from resident 3's room.*She had overheard CNA H say to resident 3 to Shut the [expletive] up on 1/11/26 in the late afternoon.*She had pushed her wheelchair to the doorway and observed CNA H standing by resident 3 after she (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education on professional communication in long term care and customer service before returning to work.*CNA H returned to work on 1/15/26.*No audits have been completed following the incident.*There had been no further follow-up with residents 3 or 4.*She expected staff to treat residents the way they wish to be treated, that this was their home, the staff were here to care for them. 11. Review of CNA H's employee file revealed:*He was hired on 9/8/25.*A background check had been completed on 8/19/25.*He completed Abuse, Neglect, and Exploitation education on 9/9/25.*He completed An Overview of Quality Dementia Care CNA education on 9/24/25.*There was a final warning written in file regarding the incident that occurred on 1/11/26. 12. Review of the provider's 4/11/25 revised Abuse and Neglect policy revealed:*Patients and residents have the right to be free from verbal, sexual, physical, mental abuse, neglect, misappropriation of property, corporal punishment, exploitation and involuntary seclusion.*Patients and residents must not be subjected to any kind of abuse by anyone, including, but not limited to, facility staff, other patients or residents, consultants, volunteer staff or other agencies serving the individual, family members, legal guardians or personal representatives, friends or other individuals.- Verbal abuse refers to any use of oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families, or within their hearing distance, to describe patients/residents, regardless of their age, ability to comprehend or disability.

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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** Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, observation, and policy review, the provider failed to protect the safety of two of two sampled resident (1, and 2) identified as at risk for elopement (leaving the facility without staff knowledge) who had exited a secured door and crawled out of a room window and left the building without staff supervision. Findings include:1. Review of the 11/22/25 SD DOH FRI report regarding resident 1 revealed:*Resident 1 was admitted to the facility on [DATE].*On the night of 11/2/25:-Resident 1 was wandering around at his baseline looking for exits.-At approximately 12:40 a.m. the south door alarm goes off.-Resident 1 is in the south hall walking back toward the nurses station/central lobby.-Nurse [registered nurse (RN) B] heads down to the far south door to turn off the alarm.-Resident 1 turns to follow and immediately pushed open the south door and leaves the building at 12:42 a.m.[RN B] Unable to see resident [1] in the parking lot.-Due to [resident 1] history of aggression and it being dark outside, the nurse [RN B] contacted law enforcement for her [RN B] personal safety.-Camera's were viewed and resident 1 was in the car [police] at 12:48 a.m. being brought to the ambulance bay door.*[Resident 1] was wearing jeans, a T-shirt and shoes.*The temperature was 35 degrees outside.*[Resident 1] was found in our facility parking lot.*On return to the care center [resident 1] is noted to be anxious with tense body posture and clenched fists.*[Resident 1] refused skin assessment and vitals.*Call with voicemail was left for family, and information was faxed to physician. 2. Review of resident 1's electronic medical record (EMR) revealed:* He had pertinent diagnoses of:-Unspecified dementia with agitation.-Depression.-Alcohol abuse, in remission.-Anxiety disorder.-Attention-deficit hyperactivity disorder, combined type.-Insomnia.*He had a roam alert (a wearable door alerting device) on his ankle starting on 4/29/25.*He had a Brief Interview for Mental Status (BIMS) score of 0, which indicated severe cognitive impairment on 9/12/25.*He was assessed on 9/11/25 and was identified as at risk for elopement.*He was administered Tylenol pm extra strength (a pain medication used for sleeplessness) on 11/1/25 at 8:45 p.m. for anxiety.*He was administered lorazepam (an anxiety medication) on 11/1/25 at 8:45 p.m. for anxiety, agitation, or behavioral disturbances.*He had been administered olanzapine (an antipsychotic medication) 5mg IM (intramuscularly) on 11/2/25 at 1:20 a.m. upon his return for behavior issues [elopement].*He had been started on 15-minute visual checks on 11/10/25.*He was sent to the emergency department (ED) on 11/26/25 for suicidal ideation.*He was discharged from the ED and transferred to a higher level of care facility (HSC).*A telephone conference was held on 12/16/25 with HSC staff regarding discharge planning related to safety concerns.*Resident 1 was discharged from facility on 12/16/25 as facility could not meet the security needs. 3. Interview on 1/28/26 at 12:04 p.m. with certified nursing assistant (CNA) C revealed:*She had worked for the facility for four and a half years.*She worked the night shift from 11/1/25 at 10:00 p.m. to 6:30 a.m. on 11/2/25.*There is one nurse and three CNA's that typically work.*Resident 1 was having behaviors of agitation, exit seeking and threats against staff.*She was unsure if as needed (PRN) medications had been given to resident 1.*She was told by registered nurse (RN) B to stay in the building for resident and staff safety at the time of the elopement.*She had not completed any elopement drills since she started working for facility.*She completed education since the incident on the new elopement policy. 4. Interview on 1/28/26 at 3:30 p.m. with RN B revealed:*She had worked at the facility for almost four years.*She worked the overnight shift from 6:00 p.m. on 111/1/25 to 6:00 a.m. on 11/2/25.*Staff communicated with each other using a walkie talkie system.*Resident 1 wore a roam alert device.*On 11/2/25 resident 1 was setting off door alarms. She was going to reset the alarm (continued on next page)

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