

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A098	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2025
NAME OF PROVIDER OR SUPPLIER Sanford Care Center Vermillion		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and policy review, the provider failed to follow industry accepted food safety standards to ensure proper glove use by cook (E) while preparing and serving residents' food during one observed meal service according to the provider's policy. Findings include: 1. Observation on 9/30/25 at 11:40 a.m. of cook E while preparing residents' food in the dining room kitchenette revealed: *With her gloved hands she: -Touched the residents' menu slips. -Opened a bag of bread and pulled slices of bread out of the bread bag and placed them on top of the hot grill. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Opened the refrigerator door, removed a bag of sliced cheese, and placed it on the counter beside the hot grill. -Touched the bread slices on the hot grill and slid them around. -Opened the bag of cheese and placed cheese slices on those slices of bread. -Opened the refrigerator door and removed a zip lock bag of two precooked burger patties. -Placed those burger patties on a plate. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Removed a plate from a stack of clean plates and placed it on the counter by the hot grill. -Opened a bag of hamburger buns and removed two buns and placed them on plates. -Touched multiple resident menu slips. -Gathered a plate, bags of chips, and ketchup packets and placed them on the counter by the hot grill. -Touched both the grilled cheese sandwiches on the hot grill. -Touched the resident menu slips. -Removed frozen hamburger patties from the freezer and placed them on the hot grill. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Touched several resident menu slips. -Opened a bag of bread, removed 4 slices of bread from that bag and placed them on the hot grill. -Handled a bag of chips. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Handled a bag of chips. -Placed two slices of cheese on the bread slices on the hot grill. -Removed two hamburger buns from the plastic bag and placed them on plates. -Closed the bag of cheese and placed it back in the refrigerator. *She then removed her gloves, washed her hands, and put on a new pair of gloves. With those gloved hands she: -Touched resident menu slips. -Maintained the grilled cheese sandwiches in place on the hot grill while she removed the edges with a spatula. -Gathered two plates from the stack of clean plates and placed them on the counter next to the hot grill. -Placed the grilled cheese sandwiches on the plates. *She then removed her gloves and washed her hands. *She gathered a plate from the stack of clean plates, flipped the hamburgers on the hot grill, and then removed a bag of sliced cheese from the refrigerator. *She put on a new pair of gloves. With those gloved hands she: -Removed two slices of cheese from the bag and placed them on the hamburgers on the hot grill. -Placed the hamburger buns on top of the bag of cheese. -Gathered plates from the stack of clean plates and plated the hamburgers. *She removed her gloves and served the plated to the residents. Interview on 9/30/25 at 12:30pm with cook E revealed: *She thought she made a mistake when handing the residents' food items with her gloved hands but was unsure. *She felt her process of making the food was bad because she had to make multiple trips to the sink to wash her hands and put on new gloves. *She agreed that she should not have touched non-food items with her gloved hands and then touch the residents' food. Interview with dietary manager D immediately following 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	above interview with cook E revealed:*She had been worried about the staff's glove use practices in the kitchen.*Some staff chose to wear gloves in the kitchen while preparing and serving the residents' food but did not follow the best process.*She was aware cook E wore gloves and touched other items before touching the residents' food.*She expected staff to use proper glove use while preparing and serving residents' food. Review of the provider's revised 2/9/25 Sanitary Service of Food policy revealed:* To prevent foodborne illness by preventing cross-contamination of foods during service.* All foods will be served in a manner that reduces possible chemical, physical, or biological contamination.* Use proper hand washing procedures to wash hands and exposed arms up to elbows prior to handling or serving any food.* Do not use bare hands to directly touch or handle any foods during food preparation or service. Gloves are to be worn to handle any food with bare hand contact when prepping food, preparing a recipe, or serving food. Gloves are not worn when using utensils to mix or serve foods.* Wash hands before putting on gloves, each time gloves must be changed, when changing tasks, before beginning to serve food with utensils.* Handle plates by the edge or rim, cups by the bottom or handle, and utensils by the handles only.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Number of residents sampled: Number of residents cited: Based on observation, interview, record review, and policy review the provider failed to ensure a formalized dining assistance program was conducted with identified family member of resident (18) who assisted resident 11 with dining. The provider also had no documentation of training for any other resident family members or visitors who offered dining assistance. Findings include: 1. Observation on 9/30/25 at 12:15 p.m. of in the dining room revealed: *A visitor used resident 18's utensils in her right hand and assisted him with eating. She then turned to her right and picked up resident 11's utensils with her right hand, and assisted resident 18 with eating. *The visitor did not wash her hands after she assisted resident 18 with eating before she assisted resident 11 with eating. 2. Interview on 9/30/25 at 12:30 p.m. with certified nursing assistant (CNA) C revealed:*She and a medication aid assisted residents with eating their meals. Resident 18's wife came in to the facility everyday to help her husband with eating, and would help other residents. *She stated resident 18's wife had not been trained to assist residents to eat but should have been. 3. Interview on 10/2/25 at 11:50 a.m. with resident 18's wife revealed:*She had not been trained regarding assisting resident with eating. She helped her husband and their friend with eating when she visited. She helped her husband and their friend with eating when she visited. She stated resident 11 could feed himself at times, but needed a little help from time to time. She helped her parents with eating in the nursing home years ago and at that time, she did not think she had to have training on assisting them. *She stated she should not have helped her friend with eating, and did not want to get anyone in trouble. *She would have called a nurse if anyone had a choking episode. *She confirmed she had used the same hand to feed both residents and stated, I only touched the end of his fork. 4. Interview on 10/2/25 at 2:16 pm with Minimum Data Set (MDS) coordinator B revealed:*She did not have a list of visitors who were trained to provide feeding assistance to the residents.*She stated resident 18's wife had approached her yesterday and asked if she could be trained so she could assist her friend with eating. *She confirmed that resident 18's wife had not been trained on providing eating assistance. 5. Review of resident 11's electronic record (EMR) revealed:*He had impaired swallowing related to history of transient ischemic attack (TIA) (stroke) and dementia (a group of symptoms affecting memory), thinking and social abilities). *He used his left hand for eating due to a deformity of his right hand and used specialized silverware to accommodate that. *He had a Brief Interview for Mental Status (BIMS) assessment score of 12 which indicated his cognition was moderately impaired. 6. Interview on 10/2/25 at 3:01 p.m. director of nursing A regarding a visitor who assisted resident 11, who had impaired swallowing with eating revealed:*She was not aware that a visitor had assisted resident 11 with eating. *She expected anyone who had assisted a resident to eat would have been trained on how to safely provide that assistance but did not have a process for that training. 7. Review of Provider's 1/31/25 Dining Assistant policy revealed, The location must ensure that a dining assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations and tube or parenteral/IV feedings. The resident selection must be based on the interdisciplinary team's assessment and the resident's latest assessment and plan of care.		