

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 431310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/07/2023
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NAME OF PROVIDER OR SUPPLIER avera flandreau hospital - CAH	STREET ADDRESS, CITY, STATE, ZIP CODE 214 NORTH PRAIRIE STREET FLANDREAU, SD 57028
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C 000 INITIAL COMMENTS

C 000

A complaint health survey for compliance with 42 CFR Part 485, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals (CAH) and Long Term Care Services ("swing bed") was conducted on 9/7/23. The area surveyed was patient abuse. Avera Flandreau Hospital was found not in compliance with the following requirements: C1004 and C1046.

C1004 PROVISION OF SERVICES
CFR(s): 485.635

C1004

§485.635 Condition of Participation: Provision of Services
This CONDITION is not met as evidenced by:
Based on record review, interview, and policy review the provider failed to ensure their policy for suspected or potential abuse for one of one patient (2) by one of one registered nurse (RN) C was followed during an investigation regarding the forceful administration of oral medications. Findings include:

Review of a complaint filed with the South Dakota Department of Health (SD DOH) revealed:
*RN C was attempting to administer oral medication to patient 2.
*Patient 2 was confused, combative, and spitting out his medications.
*RN D was holding applesauce to give with the medications for patient 2.
*RN C had instructed patient care tech (PCT) E to hold patient 2's hands down while she attempted to administer the oral medications.
*PCT E held patient 2's hands down while RN C held patient 2's jaw open with her hands administered the oral medications, and then

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Bryan J. Breitling, Administrator *Bryan J. Breitling* 10/9/23

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.

OCT 09 2023

SD DOH-OLC

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C1004	<p>Continued From page 1</p> <p>forced the patient's mouth shut with her hands. *Medical lab technician (MLT) H had been in the patient's room at the time and witnessed the above event.</p> <p>Interview and record review on 9/7/23 at 4:50 p.m. with RN B regarding the SD DOH report filed on 7/25/23 revealed: *On 6/24/23 she received a phone call from certified nurse practitioner (CNP) J regarding RN C forcing patient 2 during medication administration. *She removed RN C from caring for patient 2 but was still caring for other patients in the hospital. *RN C had not been placed on temporary leave pending an investigation related to the 6/23/23 suspected abuse. *Administrator A was contacted immediately after her phone conversation with CNP J to inform him of the situation and the plan of action. *She had initiated the investigation on 6/24/23 with an interview with RN C and resumed the investigation again on 7/24/23 when RN B had returned from vacation. *On 7/24/23 she had interviewed RN D, PCT E, and MLT H. *RN B's initial and final report was sent to the South Dakota Department of Health on 7/25/23 one month after the potential abuse to patient 2 had occurred.</p> <p>Review of the provider's April 2023 Corrective Action policy revealed: *"Employees are expected to conduct themselves in a manner consistent with the provider's mission, care standards for service excellence, and all applicable rules, regulations, laws, and policies."</p>	C1004	<p>C1004: MLT H filed an internal risk management report on 6-24-23. The RN B called RN C and directed RN C not to be the primary caregiver to Patient #2 for the duration of Patient # 2's stay. RN B conducted an investigation and consulted with human resources and administrator. The Director of Nursing will develop a "Reporting Suspected Abuse" checklist for managing abuse allegations and a medication administration direct observation checklist. The Director of Nursing will assign dementia and Alzheimer's disease education, suspicion of patient abuse and neglect education, education on the Adult protective service reporting policy (which includes education on definitions, characteristics, indicators, and procedures for reporting abuse or neglect), and incident reporting, to the nursing department through the nursing department learning center due by October 13th. The DON will educate or review with nursing staff, the policies, checklists and Avera Corrective Action policy, at the October 17th Nursing Staff Inservice, to reinforce medication administration and care for the elderly with all nursing staff. The Reporting Suspected Abuse checklist will be reviewed weekly until compliance is achieved, then monthly, by the director of nursing. The Director of Nursing or outpatient coordinator will complete a visual audit of nurse medication administration and record those audits on the medication administration direct observation checklist. The audits will be structured via 3x/wk, varying shifts and varying staff. Once the audits achieve the targeted 95% compliance for two weeks, the audits will transition to 2x/wk for various staff and shifts. The ratio of visual audits will continue the pattern of decreasing as compliance is achieved. The director of nursing will report the checklist to the quality control committee quarterly. The administrator will monitor for one year.</p>	10/17/23	

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C1004	Continued From page 2 *A formal process where the provider may, depending on the nature and severity of the issue, suspend an employee with or without pay when there is immediate need to remove the employee from the work place." -"Examples of when an employee should be suspended pending an human resource investigation include, but no limited to:" --"A situation that involves allegation of abuse by an employee."	C1004		
C1046	Refer to: C1046. NURSING SERVICES CFR(s): 485.635(d)(1) Nursing services must meet the needs of patients. (1) A registered nurse must provide (or assign to other personnel) the nursing care of each patient, including patients at a SNF level of care in a swing-bed CAH. The care must be provided in accordance with the patient's needs and the specialized qualifications and competence of the staff available. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review the provider failed to ensure one of one sampled patient (2) was not physically forced to take his medication by one of one registered nurse (RN) C during oral medication administration. Findings include: Review of patient 2's electronic medical record (EMR) revealed: *He was a 76 year old and had been admitted from his own home on 6/22/23. *Admitting diagnoses included:	C1046		

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C1046	<p>Continued From page 3</p> <p>-Dehydration, loose stools, and pneumonia.</p> <p>*He had a past medical history of the following: Parkinson's disease with psychosis, and dementia.</p> <p>*He was treated with intravenous (IV) fluids, and IV antibiotics.</p> <p>*The date of discharge to a long-term care facility was on 6/28/23.</p> <p>Review of the South Dakota Department of Health report that was received revealed the following:</p> <p>*On 6/23/23 RN C was attempting to administer oral medications to patient 2.</p> <p>*Patient 2 had been confused, combative, and had refused to take his oral medications for RN C.</p> <p>*RN D had entered patient 2's room to attempt to administer the medications to the patient.</p> <p>*Patient Care Tech (PCT) E had entered patient 2's room and was instructed by RN C to hold patient 2's hands down since he was striking out at staff during the attempt to administer those medications.</p> <p>*RN C then grabbed patient 2's jaw with her hands, forcefully opened his mouth, gave him the medications, and then closed his mouth holding it shut with her hand.</p> <p>*MLT H had been in the patient's room while the medications had been administered.</p> <p>Interview on 9/7/23 at 12:05 p.m. with medical lab technician (MLT) H regarding the above event revealed:</p> <p>*She had witnessed the event and spoke with RN D and PCT E following the event.</p> <p>*PCT E had stated that she thought the whole situation was "barbaric".</p> <p>*MLT H informed RN D and PCT E that was</p>	C1046	<p>C1046: RN C attempted to give oral medications to patient #2 on 6-22-23. Due to patient #2 confused and combative state and RN C's unsuccessful attempts, the decision was made to suspend medication attempt and notify the provider.</p> <p>The Director of Nursing will assign dementia and Alzheimer's disease education, suspicion of patient abuse and neglect education, education on the Adult protective service reporting policy, and incident reporting, to the nursing department through the nursing department learning center due by October 13th, and reviewed at the October 17, 2023 nursing inservice, to reinforce medication administration and care for the elderly with all nursing staff.</p> <p>The Director of Nursing will verify that all nursing staff participate in and receive the education, and will report it to the quality control committee at our next quarter committee meeting. Any new nursing staff will be trained and educated in their month of hire and reported at the next quality control quarterly meeting. The administrator will monitor this training and reporting for one year.</p> <p>Using the medication administration checklist, the Director of Nursing or Outpatient Coordinator, will visually audit medication administration to ensure education on dementia/confused/Alzheimers patients is implemented, and record those audits on the medication administration direct observation checklist. The audits will be structured via 3x/wk, varying shifts and varying staff. Once the audits achieve the targeted 95% compliance for two weeks, the audits will transition to 2x/wk for various staff and shifts. The ratio of visual audits will continue the pattern of decreasing as compliance is achieved. The director of nursing will report the checklist to the quality control committee quarterly. The administrator will monitor for one year.</p>	10/17/23

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C1046	<p>Continued From page 4</p> <p>patient abuse by RN C.</p> <p>*On 6/24/23 MLT H filed an internal Risk Management report regarding her observation of the event on 6/23/23.</p> <p>*She had spoken with certified nurse practitioner (CNP) J on 6/24/23 and informed her of her observation on 6/23/23.</p> <p>*MLT H had left for vacation on 6/25/23 and returned to work on 7/12/23 she verified with RN I that her internal Risk Management report had been received.</p> <p>*RN B had contacted MLT H on 7/25/23 and met with RN B in person to get the information regarding the above event.</p> <p>Interview on 9/7/23 at 1:00 p.m. with RN F regarding oral medication administration to a confused and agitated patient revealed:</p> <p>*She would have explained to the patient that she was giving them their medication.</p> <p>*Evaluation of the explanation and the patient's response would have determined if medication should have been administered at that time or to wait a period of time and reapproach the patient.</p> <p>*Combative patients who were hitting and kicking staff would indicate that the patient was not receptive to the oral medication administrations.</p> <p>*RN F would have then contacted the provider to change the route of administration or inform the provider the patient refused that medication.</p> <p>*She would not have forcefully opened a patient's mouth and forced it shut to administer a medication to a patient.</p> <p>Interview on 9/7/23 at 1:10 p.m. with PCT E regarding the incident of physically forceful medication administration to patient 2 on 6/23/23 revealed:</p> <p>*She had heard loud voices coming from patient</p>	C1046		

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C1046	<p>Continued From page 5</p> <p>2's room.</p> <p>*RN C was having trouble administering patient 2 oral medications.</p> <p>*RN D had entered the patient's room to assist with the oral medication administration.</p> <p>*RN C instructed her to hold patient 2's hands down due to him hitting staff during the attempted medication administration.</p> <p>*RN C had one hand over patient 2's nose and one under his jaw, she moved her hand over the patient's nose and used the other hand to administer the medication. RN C then held his clamped her hand over the patient's mouth.</p> <p>*PCT E stated that she thought it was "barbaric" to administer medication in that manner.</p> <p>Interview on 9/7/23 at 1:14 p.m. with RN G regarding oral medication administration to a confused and combative patient revealed:</p> <p>*She would have tried to redirect the patient and explain what the medication was for and then assess for the patient's comprehension.</p> <p>*Patients that were combative, she would not attempt to administer the medication and would have tried to calm them down.</p> <p>*She would have contacted the provider and suggest a possible alternative route for medication administration.</p> <p>Interview on 9/7/23 at 1:30 p.m. with RN I regarding receiving a internal Risk Management report filed on 6/24/23 regarding patient 2 revealed:</p> <p>*She had received the report on 6/26/23 when she had returned to work.</p> <p>*She would fill in as the director of patient care services if RN B was on leave.</p> <p>Interview on 9/7/23 at 2:03 p.m. with RN C</p>	C1046			

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C1046	<p>Continued From page 6</p> <p>regarding her medication administration on 6/23/23 with patient 2 revealed:</p> <ul style="list-style-type: none"> *She was in the patient's room by herself trying to get him to take his oral medication Sinemet 25/100 milligrams (mg) and Mirtazapine 15 mg. *Patient 2 had accepted the medications she had administered on 6/22/23. *Patient 2 was confused, and she had spoken with him for approximately 15 minutes to convince him to take his medication. *She had attempted to crush the medication and administer them in applesauce. *Patient 2 continued to spit out the medication. *RN D had been asked to administer the medication to patient 2. *Patient 2 was hitting and kicking at staff. *She instructed PCT E to hold patient 2's hands down and then she opened his lips "like a fish" squeezing on both sides of his cheeks. *Patient 2's mouth was open and then she administered the medication in applesauce, and he then spit them back out. *She then contacted the provider to get an alternative medication that could have been administered IV for his behaviors. *RN C then administered lorazepam 0.25 mg IV to patient 2 per the provider's order. *Dementia training was not provided to the staff. *She had to have assistance with holding patient 2's hands down on other occasions to have gotten them to take his medications. *She had thought she had tried everything to get him to take his medications. <p>Interview on 9/7/23 at 2:35 p.m. with RN D regarding the medication administration on 6/23/23 with patient 2 revealed:</p> <ul style="list-style-type: none"> *She had entered patient 2's room due to RN C being away from the nurse's station for 20-30 	C1046		

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C1046	<p>Continued From page 7</p> <p>minutes.</p> <p>*Loud words and screaming from patient 2's room was heard in the hallway.</p> <p>*She had worked with patient 2 for a couple of nights and was familiar with him.</p> <p>*Patient 2 had been combative on 6/22/23 and she had reported that to the oncoming shift on 6/23/23.</p> <p>*She had noticed that PCT E was talking with patient 2 to try and get him to take his medication from RN C.</p> <p>*RN C had tried applesauce and pudding to help aid with the medication administration without success.</p> <p>*RN C pinched patient 2's cheeks like a "kissy face" and forced the medication into his mouth.</p> <p>*Patient 2 then spit out those medications</p> <p>*RN C then stated, "We're done."</p> <p>*She would not have tried as long to get patient 2 to take his medication.</p> <p>*She would not have placed her hands on the patient, nor would she have had someone hold the patient's hands down while attempting to give medication.</p> <p>Interview on 9/7/23 at 4:50 p.m. with administrator A and RN B regarding patient 2's medication administration on 6/23/23 and the suspected abuse allegation revealed:</p> <p>*On 6/24/23 RN B received a phone call from CNP J regarding the concern that had been brought to her attention involving RN C.</p> <p>*She contacted administrator A to inform him of the situation.</p> <p>*She had contacted RN C to get her perspective on what happened on 6/23/23</p> <p>*RN B informed RN C not to provide any care to patient 2 on 6/24/23.</p> <p>*She had spoken to MLT B on 7/25/23 to get her</p>	C1046		

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C1046	<p>Continued From page 8</p> <p>account of the incident on 6/23/23.</p> <p>*Once RN B had gathered her information and shared all that information to human resources.</p> <p>*Administrator A was not involved in the interviewing of staff.</p> <p>*They both had not felt that RN C using her hand to make a "kissy face" to get him to take his medication was abuse.</p> <p>*They had both felt that holding a patient's hands down depended on the situation.</p> <p>*Administrator A had informed us that human resources had felt that there was no abuse, so they did not treat it as such.</p> <p>*Neither administrator A nor RN B had followed their Corrective Action policy.</p> <p>*They both had confirmed that RN C had been working and continued to care for other patients during the investigation process.</p> <p>*RN C was hired in 2003 had worked for the facility for 20 years, and there were no concerns with her performance.</p> <p>*They wanted to give RN C the benefit of the doubt.</p> <p>*Neither administrator A nor RN B had thought about the psycho-social affect that could have had on patient 2.</p> <p>Review of the provider's June and July 2023 nursing schedule for the dates of 6/23/23 through 7/25/23 revealed:</p> <p>*RN C had worked 20 out of 32 shifts during that period.</p> <p>*She had not been placed on temporary leave pending an investigation related to the 6/23/23 suspected abuse.</p> <p>Review of the provider's January 2023 Abuse Elder, Suspected or Alleged policy revealed:</p> <p>**Abuse: means physical harm, injury or attempt</p>	C1046		

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C1046	Continued From page 9 to cause physical harm or injury or the infliction of fear of imminent physical harm or body injury." Review of the provider's April 2023 Corrective Action policy revealed: *"Employees are expected to conduct themselves in a manner consistent with the provider's mission, care standards for service excellence, and all applicable rules, regulations, laws, and polices." *A formal process where the provider may, depending on the nature and severity of the issue, suspend an employee with or without pay when there is immediate need to remove the employee from the workplace." -"Examples of when an employee should be suspended pending a human resource investigation include, but not limited to:" --"A situation that involves allegation of abuse by an employee."	C1046			

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement A complaint survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted on 9/7/23. Avera Flandreau Hospital was found not in compliance with the following requirement: S115.	S 000		
S 115	44:75:01:07 Reports Each facility shall fax, email, or mail to the department the pertinent data necessary to comply with the requirements of all applicable administrative rules and statutes. Any incident or event where there is reasonable cause to suspect abuse or neglect of any patient by any person shall be reported within 24 hours of becoming informed of the alleged incident or event. The facility shall report each incident or event orally or in writing to the state's attorney of the county in which the facility is located, to the Department of Social Services, or to a law enforcement officer. The facility shall report each incident or event to the department within 24 hours, and conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event. Each facility shall report to the department within 48 hours of the event any death resulting from other than natural causes originating on facility property such as accidents or suicide patient. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.	S 115	S115: MLT H filed an internal risk management report on 6-24-23. RN B conducted an investigation and consulted with human resources and administrator. After the SD Dept of Health reached out, RN B filed an initial and final report on 7-25-23. By the next business day, the Director of Nursing or hospital administrator will file a report with the SD Dept of Health following each internal risk management report or patient complaint of alleged abuse at Avera Flandreau. All facility staff will be notified of this process through a facility news email by the administrator. A spreadsheet of Internal Risk Management reports and alleged patient complaints of abuse, will be compiled and reviewed weekly until compliance is achieved, then monthly, by the director of nursing. The director of nursing will report the internal risk management and alleged patient complaint of abuse report to the quality control committee quarterly. The administrator will monitor for one year.	10/17/23

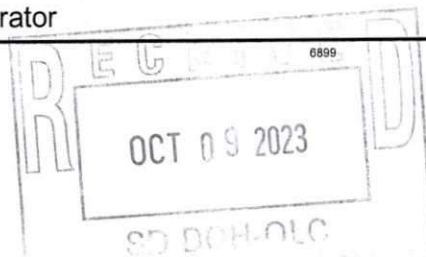
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Bryan J. Breitling, Administrator

9/29/23



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10540 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/07/2023
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NAME OF PROVIDER OR SUPPLIER AVERA FLANDREAU HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 214 N PRAIRIE STREET FLANDREAU, SD 57028
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 115	<p>Continued From page 1</p> <p>Each facility shall report a missing patient to the department within 48 hours. The facility shall conduct a subsequent internal investigation and provide a written report of the results to the department within five working days after the event.</p> <p>Each facility shall also report to the department as soon as possible any fire with damage or where injury or death occurs; any partial or complete evacuation of the facility resulting from natural disaster; or any loss of utilities, such as electricity, natural gas, telephone, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours.</p> <p>Each facility shall notify the department of any anticipated closure or discontinuation of service at least 30 days in advance of the effective date.</p> <p>Each facility shall report to the department any unsafe water samples for pools or spas.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review the provider failed ensure a report was submitted to the South Dakota Department of Health (SD DOH) in a timely manner for potential abuse for one of one sampled registered nurse (RN) C who had administered oral medication to one of one sample patient (2) who had been confused, combative, and attempting to spit out the medication. Findings include:</p> <p>Review of a complaint filed with the South Dakota Department of Health revealed: *Registered nurse (RN) C was attempting to administer oral medication to patient 2.</p>	S 115		
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10540 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 09/07/2023
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NAME OF PROVIDER OR SUPPLIER AVERA FLANDREAU HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 214 N PRAIRIE STREET FLANDREAU, SD 57028
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 115	<p>Continued From page 2</p> <p>*Patient 2 was confused, combative, and spitting out his medications.</p> <p>*RN D was holding applesauce to give with the medications for patient 2.</p> <p>*RN C had instructed patient care tech (PCT) E to hold patient 2's hands down while she attempted to administer the oral medications.</p> <p>*PCT E held patient 2's hands down while RN C held patient 2's jaw open with her hands administered the oral medications, and then forced the patient's mouth shut with her hands.</p> <p>*Medical lab technician (MLT) H had been in the patient's room at the time and witnessed the above event.</p> <p>Interview on 9/7/23 at 12:05 p.m. with MLT H regarding the administration of oral medications to patient 2 revealed:</p> <p>*MLT H was in the patient's room to inform RN C that an intravenous (IV) infusion of fluids was completed for another patient when she witnessed PCT E holding patient 2's hands down and RN C holding patient 2's jaw open, administering the medications in the patient's mouth and then forcing the mouth shut with her hands.</p> <p>*She had spoken to PCT E and RN D shortly after the above incident and informed them that they had witnessed patient abuse.</p> <p>*She had spoken to certified nurse practitioner (CNP) J on 6/24/23 and informed her of the witnessed event on 6/23/23.</p> <p>*MLT H had filed an internal Risk Management report using the hospital's electronic medical record system on 6/24/23.</p> <p>-That report was sent to RN B and RN I.</p> <p>*On 7/12/23 MLT H verified with RN I that the 6/24/23 internal Risk Management report had been received on 6/24/23.</p>	S 115		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10540 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/07/2023
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NAME OF PROVIDER OR SUPPLIER AVERA FLANDREAU HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 214 N PRAIRIE STREET FLANDREAU, SD 57028
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S 115	<p>Continued From page 3</p> <p>Interview on 9/7/23 at 1:30 p.m. with RN I regarding the internal Risk Management report that was received on 6/24/23 revealed: *She had received the report on 6/24/23 which was a Saturday but had not opened the report until Monday on 6/26/23. *She was unsure when RN B had reviewed the report.</p> <p>Interview and record review on 9/7/23 at 4:50 p.m. with RN B regarding the South Dakota Department of Health report filed on 7/25/23 revealed: *On 6/24/23 she received a phone call from CNP J regarding RN C forcing patient 2 during medication administration. *She removed RN C from caring for patient 2 but was still caring for other patients in the hospital. *Administrator A was contacted immediately after her phone conversation with CNP J to inform him of the situation and the plan of action. *She had initiated the investigation on 6/24/23 with an interview with RN C and resumed the investigation again on 7/24/23 when RN B had returned from vacation. *On 7/24/23 she had interviewed RN D, PCT E, and MLT H. *RN B's initial and final report was sent to the South Dakota Department of Health on 7/25/23 one month after the potential abuse to patient 2 had occurred.</p> <p>Review of the provider's January 2023 Abuse Elder, Suspected or Alleged policy revealed: **Purpose: To establish guidelines to identify and report suspected abuse, neglect or exploitation of an elder or disabled adult patient or a patient unable to care for themselves." "Abuse means physical harm, bodily injury or attempt to cause physical harm or injury or the</p>	S 115		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10540 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/07/2023
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NAME OF PROVIDER OR SUPPLIER AVERA FLANDREAU HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 214 N PRAIRIE STREET FLANDREAU, SD 57028
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S 115	Continued From page 4 infliction of imminent physical harm or bodily injury on an elder or disabled adult.	S 115		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10540 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2023
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NAME OF PROVIDER OR SUPPLIER avera flandreau hospital	STREET ADDRESS, CITY, STATE, ZIP CODE 214 N PRAIRIE STREET FLANDREAU, SD 57028
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{S 000}	<p>Compliance/Noncompliance Statement</p> <p>An onsite revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, and Critical Access Hospital Facilities, was conducted on 10/20/23. Avera Flandreau Hospital was found in compliance.</p>	{S 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/23/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 431310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2023
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NAME OF PROVIDER OR SUPPLIER AVERA FLANDREAU HOSPITAL - CAH	STREET ADDRESS, CITY, STATE, ZIP CODE 214 NORTH PRAIRIE STREET FLANDREAU, SD 57028
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{C 000}	<p>INITIAL COMMENTS</p> <p>An onsite revisit survey was conducted on 10/20/23 for compliance with 42 CFR Part 484, Subpart F, Subsections 485.605-485.645, requirements for Critical Access Hospitals for all previous deficiencies cited on 9/7/23. All deficiencies have been corrected and no new non-compliance was found. Avera Flandreau Hospital was found in compliance with all regulations surveyed.</p>	{C 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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.