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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A139	A. BUILDING _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR FLANDREAU, SD 57028

(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
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 04/02/24 through 04/04/24. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirements: F604 and F812.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive	F 604	On 4/23/24, Admin and DON reviewed/ revised Restraint Free Environment policy. On 4/21/24, assessment on resident 11 was completed by DON for seatbelt and splint needs. On 4/21/24. Current physician order for devices was located and uploaded into the residents medical file. Resident's care plan was reviewed and revised on 4/23/24 to reflect resident's restraint needs and use. All residents have the potential to be affected. An audit was completed by MDS Coordinator and designee on all residents in facility for restraint assessments, orders, and care plans on 4/23/24. All licensed nursing staff was educated on resident rights and facility policy regarding restraint free environments on 4/23/24 by the DON. Any remaining licensed staff will be educated propr to next shift worked. Admission procedures were reviewed and revised on 4/22/24 to include a checklist for identification, assessing, order obtainment, and care planning. Quarterly procedures were reviewed and revised on 4/22/24 to included a checklist for continued identification, assessing, and care planning. The DON and/or designee will complete audits on residents to ensure they are free from restraints or have proper physician	4/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty
TITLE: LNHA
(X6) DATE: 4/24/24

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.

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F 604	Continued From page 1 alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, electronic medical record review, interview, and policy review, the provider failed to ensure one of one sampled resident (11) with a diagnosis of quadriplegia had an accurate assessment that included a physician acknowledgment order for the use of a seatbelt and wrist splints. Findings include: 1. Observation on 4/2/24 at 3:05 p.m. with resident 11 revealed he was: *Sitting in a motorized wheelchair with a locked seatbelt across his lap helping keep him in an upright position in the chair. *Not wearing wrist splints. 2. Review of resident 11's electronic medical record (EMR) revealed: *He was admitted on 10/17/2023. *His diagnoses included quadriplegia. *There was no physician's order for the seatbelt. *There was a physician's order for the wrist splints. *No assessments for the use of the seatbelt or the wrist splints. *The 2/1/24 care plan did not include the use of the seatbelt or the wrist splints. 3. Interview on 4/4/24 at 1:42 p.m. with director of nursing (DON) B regarding restraint use for resident 11 revealed: *She had completed the Minimum Data Set (MDS) [a standardized assessment tool used by all long-term care facilities certified to participate in Medicaid] with an assessment reference date	F 604	orders for any safety restraint device 2x per week for 2 weeks and 1x per week for 4 weeks. The DON and/or designee will report findings and identified concerns to the facility's QAPI Program for review and recommendations.	

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F 604	Continued From page 2 (ARD) of 1/30/24. *The seatbelt was coded as a trunk restraint. *The wrist splint was coded as a limb restraint. *She stated: -Those items were not assessed as potential restraints. -There should have been a physician's order for the use of the restraints. -Resident 11 was admitted from another facility with the motorized wheelchair and wrist splints and would have been assessed there. -Restraints should be addressed in the care plan. 4. Interview on 4/4/24 at 1:47 p.m. with resident 11 revealed he: *Wore a seatbelt when up in the motorized wheelchair. *Had not been able to put on or remove the seatbelt himself. *Had wrist splints that he wore "sometimes". *Had not been able to put on or remove the wrist splints himself. Review of the provider's 6/25/23 "Restraint Free Environment" policy revealed: *"Physical restraints may include, but are not limited to: Applying leg or arm restraints, hand mitts, soft ties or vests that the resident cannot remove... Using devices in conjunction with a chair such as ...belts, that the resident cannot remove." *"A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint." *"Before a resident is restrained, the facility will determine... b. The length of time the restraint is anticipated to be used... who may apply the restraint and the	F 604		

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F 604	Continued From page 3 time and frequency that the restraint will be released. c. The type of direct monitoring and supervision that will be provided during use of the restraint." *"The resident's record needs to include documentation that less restrictive alternatives were attempted, ...ongoing re-evaluation of the need for the restraint. The care plan should be updated accordingly..."	F 604		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure three of three kitchen staff (H, K, and L) had: *Practiced appropriate hand hygiene and glove use during two of two meal preparations.	F 812	On 4/23/24 the Administrator and Registered Dietician reviewed/ revised facility policy on Food Preparation and Service. On 4/23/24 the Administrator and Registered Dietician educated dietary staff members H, K, and L on proper glove use, thermometer use and sanitation, and hand hygiene. Dietary staff members H, K, and L completed competencies on proper glove use, thermometer use and sanitation, and hand hygiene. The Dietary Manager and/or designee will audit meal time prep and food serving practices 3x per week for 4 weeks, then 1x per week for 4 weeks. The Dietary Manager and/or designee will report findings and identified cerns to the facilities QAPI Program for review and recommendations.	4/28/24

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F 812	Continued From page 4 *Performed proper sanitation of the food thermometer while temping the food items before serving the residents. Findings include: 1. Observation on 4/3/24 at 8:17 a.m. in the main kitchen with cook H revealed he: *Used a cloth to remove a hot pan of bacon from the oven. *Checked the temperature of the bacon with a thermometer, used that same cloth to wipe off the thermometer, and sat the thermometer on the counter. *Used that same cloth to remove several other food items from the oven. *Continued to use that same uncleaned thermometer and wiped it off with that same cloth while he checked the temperatures of the eggs and oatmeal. 2. Continued observation on 4/3/24 at 8:25 a.m. in the main kitchen with cook H revealed: *He had on a pair of single-use gloves. *While wearing those gloves he opened the refrigerator removed a container of sausage and placed the sausage on the grill. *He removed those gloves and without completing hand hygiene put on a new pair of gloves. *While wearing those gloves he opened the refrigerator and removed a roll and package of cheese. *With those same gloves on, he opened the cheese, removed one slice from the stack, rewrapped the cheese, and placed it back in the refrigerator. *With those same gloved hands touched a spatula, butter container, drawer handle, and another utensil which he placed in the butter container.	F 812		

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F 812	Continued From page 5 *With those same gloved hands he moved a sandwich from the grill and placed it in foil wrap. *He removed those gloves, washed his hands, and blew on his wet hands to dry them, and put on a new pair of gloves. 3. Interview during kitchen observations on 4/3/24 at 08:41 a.m. with director of food services C regarding the "smart power cleaning solution system" revealed: *A cloth is kept in the solution. *It is used for cleaning kitchen surfaces. *The cloth can be reused and is changed when it becomes heavily soiled. 4. Observation on 4/3/24 at 8:59 a.m. with cook H in the unit dining area revealed: *A cloth in a container of Smart Power cleaning solution. *He used the food thermometer to take the temperature of the eggs. *After he checked the temperature of the eggs, he dipped the food thermometer in the cleaning solution and wiped it off with the cloth that had been stored in the cleaning solution container. *He used that thermometer, while still wet with the cleaning solution, to check the temperature of the oatmeal. *He repeated those same steps to check the temperature of the bacon. 5. Observation on 4/3/24 at 4:26 p.m. in the main kitchen with dietary aide K and cook L revealed: *Dietary aide K used the thermometer to take the temperature of the potato salad and without cleaning it took the temperature of the coleslaw. *Cook L used that same unclean thermometer to check the temperature of the hotdogs.	F 812		

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F 812	Continued From page 6 6. Interview on 4/4/24 at 1:18 p.m. with cook H revealed he: *Had worked in the kitchen for approximately eight months. *Received training on the use of gloves during food preparation when he was hired. *Had studied the serve safe book. *Wore gloves while he prepared food but was not allowed to wear them in the unit while he served the food. *Cleaned the food thermometer by wiping it on a "dry rag with each use." *Used an alcohol wipe to clean the food thermometer when he was finished taking temperatures of the food items. 7. Interview on 4/4/24 at 1:23 p.m. with director of food services C regarding the use of gloves, hand hygiene, and the cleaning of the food thermometer revealed: *Staff are provided training on the use of gloves, hand hygiene, and the correct procedure for using the food thermometer when they are hired. *Signs indicating how to wash hands and change gloves are posted at each sink in the kitchen. *"Staff are encouraged to wear gloves only when they are required to when touching food." *She expected staff to wash their hands after removing their gloves and before putting new gloves on. *Alcohol wipes for cleaning the thermometer were kept in the main kitchen and the unit serving areas. *Staff were not to use the smart power cleaning solution or a cloth to clean the thermometer. *She expected staff to "clean the thermometer after each food was temped with an alcohol wipe."	F 812		

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F 812	Continued From page 7 8. Review of the provider's 2/12/23 "Food Borne Illness - Employee Hygiene" policy revealed: *"Employees must wash their hands: ... g. during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks ..." *"Contact between food and bare (ungloved) hands is prohibited." *"Gloves are considered single-use items and must be discarded after completing the task for which they are used. The use of gloves does not substitute for proper hand washing." Review of the provider's April 2019 "Food Preparation and Service" policy revealed: *"Appropriate measures are used to prevent cross contamination. These include: *"Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spreads of foodborne illness." *"Food thermometers used to check food temperatures are clean, sanitized and calibrated for accuracy."	F 812		

South Dakota Department of Health

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	80038	A. BUILDING: _____ B. WING _____	04/04/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 04/02/24 through 04/04/24. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on	S 206	Employees D, E, F, G, H, and I were trained on incidents and diseases subject to mandatory, the facilities reporting mechanisms, and proper restraing use by the Administrator and/or designee by 4/28/24. Individuals not in attendance by this date will be trained prior to their next shift. Employees D, E, H, and I were trained on accident prevention and safety procedures by Administrator and/or designee by 4/28/24. Individuals not in attendance by this date will be trained prior to their next shift. Employees D, E, and I were trained on infection control and prevention by Administrator and/or designee by 4/28/24. Individuals not in attendance by this date will be trained prior to their next shift. Employees G and I were trained on emergency procedures and preparedness and fire prevention and response by Administrator and/or designee by 4/28/24. Individuals not in attendance by this date will be trained prior to their next shift. All other staff to be educated or re-educated by Administrator and/or designee on 11 required subjects by 4/28/24 to ensure all staff are up to date on trainings. Individuals not in attendance by this date will be trained prior to next shift. A new training schedule was drafted and adopted by the QAPI team on 4/22/24. An employee yearly and orientation education policy was drafted and sent to the governing board for approval on 4/22/24. Administrator and/or designee will audit employee education completion for 10	4/28/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty — TITLE: LNHA — (X6) DATE: 4/24/23

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S 206	Continued From page 1 facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on employee personnel records review, interview, and policy review, the provider failed to ensure the annual required training was completed for: *Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms and proper restraint use for six of six sampled employees (D, E, F, G, H, and I). *Accident prevention safety procedures for four of six sampled employees (D, E, H, and I). *Infection control and prevention for three of six sampled employees (D, E, and I). *Emergency procedures and preparedness, and fire prevention and response for two of six sampled employees (G and I). 1. Review of employee personnel records revealed: *Employee D was hired on 6/5/23 and had no record of education about incidents and diseases subject to mandatory reporting and proper restraint use, accident prevention safety procedures, and infection control and prevention. *Employee E was hired on 3/15/23 and had no record of education about incidents and diseases subject to mandatory reporting and proper restraint use, accident prevention safety procedures, and infection control and prevention. *Employee F was hired on 4/5/23 and had no record of education about incidents and diseases subject to mandatory reporting and proper restraint use. *Employee G was hired on 4/14/23 and had no record of education about incidents and diseases subject to mandatory reporting and proper	S 206	employees for 2 months. Then 5 employees for 2 months or until substantial compliance is achieved. The Administrator and/or designee will report findings and identified concerns to the facility's QAPI Program for review and recommendations.	

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S 206	Continued From page 2 restraint use, emergency procedures and preparedness, and fire prevention and response. *Employee H was hired on 7/11/23 and had no record of education about incidents and diseases subject to mandatory reporting and proper restraint use, and accident prevention safety procedures. *Employee I was hired on 9/27/23 and had no record of education about incidents and diseases subject to mandatory reporting and proper restraint use, accident prevention safety procedures, and emergency procedures and preparedness, and fire prevention and response. Interview and review of employee personnel records on 4/4/24 at 11:30 a.m. with chief human resources officer J revealed: *They used in-person and on-line training programs for employees. *She was responsible for filing the employees' training certificates of completion. *She was not aware there were eleven required annual training topics. *She agreed those employees had not completed their training. Interview on 4/4/24 at 1:45 p.m. with administrator A regarding employee training revealed: *Employees were assigned on-line education after they were hired. *She was responsible for ensuring each employee's training was completed as required. *She confirmed employees D, E, F, G, H, and I had not completed the required training. Review of the provider's 10/16/23 employee training policy revealed: *"The facility shall provide staff with appropriate information and instruction through various	S 206		

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S 206	Continued From page 3 means, including initial orientation and ongoing training programs." *"Personnel are required to attend and participate in task and job specific education programs."	S 206		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 04/02/24 through 04/04/24. Flandreau Santee Tribe Care Center was found in compliance.	S 000		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 04/02/24 through 04/04/24. Flandreau Santee Sioux Tribe Care Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty
TITLE: LNHA
(X6) DATE: 4/24/23

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A139	A. BUILDING **01 - FLANDREAU SANTEE SIOUX TRIBE CARE CENTER** B. WING _____	**04/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	**909 JONES DR FLANDREAU, SD 57028**

(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
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 new health care occupancy) was conducted on 4/3/24. Flandreau Santee Sioux Tribe Care Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K353 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353	Quarterly flow inspection was completed on 4/12/24. Administrator provided education about sprinkler system flow reguation to the Facilities Director on 4/23/24. Service contract with The Fire Group was put into affect on 4/4/24 to completed quarterly sprinkler flow inspections to ensure continued compliance. The Facilities Director will report identified concerns through the facilities QAPI Program.	4/24/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kassie Doty — TITLE: LNHA — (X6) DATE: 4/24/24

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K 353	Continued From page 1 Based on document review, interview, and observation, and the provider failed to ensure the sprinkler system was tested and maintened in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The required quarterly testing of the sprinkler system waterflow sensing devices were not being conducted. Findings include: 1. Document review and interview on 4/3/24 at 2:25 p.m. revealed the director of maintenance was unable to provide documentation of the required quarterly testing of the waterflow sensing devices on the fire sprinkler system. He indicated he had not conducted the quarterly flow tests because he was not aware they were necessary. He had a copy of NFPA 25 and was later able to find the requirement.	K 353		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to demonstrate quarterly fire drills	K 712	A night shift drill was completed on 4/23/24. Facilities Director was educated on 4/23/24 by the Administrator on fire drill requirements. The Administrator and/or designee will audit fire drill reports monthly for 3 months and then randomly to ensure continued compliance. The Administrator and/or designee will report identified concerns through the facilities QAPI Program.	4/24/24

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K 712	Continued From page 2 were conducted during four of the last four quarters for each of the three working shifts (no third-shift drills were conducted). Findings include: 1. Review of the fire drill records on 4/3/24 at 3:00 p.m. revealed drills were conducted at least once per each of the past twelve months. However, no night-shift drills were conducted. Interview with the director of maintenance during the document review confirmed that condition. He further stated he had recently hired a maintenance technician who would be able to conduct third-shift drills.	K 712		