STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLANDREAU ... B. WING	(X3) DATE SURVEY COMPLETED 09/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
K0000 Bldg. 01	INITIAL COMMENTS A recertification survey was conducted on 9/15/26 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Flandreau Santee Sioux Tribe Care Center was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321 and in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K0000	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of fault by the Executive Director/ Administrator or any employees, agents or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of survey as condition of participation in Title 18 and Titel 19 programs. This plan of correction is submitted as the facility's credible allegation of compliance.	
K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 New Hazardous areas are protected in accordance with 18.3.2.1. The areas shall be enclosed with a 1-hour fire-rated barrier, with a 3/4-hour fire-rated door without windows (in accordance with 8.7.1.1). Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, and 8.4. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 18.3.2.1, 7.2.1.8, 8.4, 8.7, 9.7 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms	K0321		

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 reverse for further 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
NHA	Administrator	10/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - FLANDREAU ... B. WING	(X3) DATE SURVEY COMPLETED 09/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
K0321 SS = D Bldg. 01	Continued from page 1 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 and less than 100 square feet) g. Combustible Storage Rooms/Spaces (over 100 square feet) h. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation, testing, and interview, the provider failed to maintain the fire-rated doors for one randomly observed hazardous area (east garage) as required. Findings include: 1. Observation on 9/15/26 at 10:27 a.m. revealed the east garage was over 100 square feet and contained combustible items. The Fire-rated set of double doors to the corridor for that room would not close and latch. Testing of that set of doors revealed the automatic flush bolt in the passive door leaf was broken. For that set of door leaves, the automatic flush bolt needs to engage with the door frame when the active leaf closes for either leaf to latch. Interview with the maintenance technician at the time of the observation confirmed those findings. He indicated that automatic flush bolt system in the inactive leaf had recently broken and they had not yet had a chance to fix it. The deficiency affected one of numerous requirements for hazardous storage rooms.	K0321	Hazardous Areas - Enclosure 1. Deficiency: The Fire-rated set of double doors to the corridor for that room would not close and latch. 2. Corrective Action: A new locking bolt has been installed by the maintenance technician to ensure that the inactive leaf would close and latch. 3. Monitoring: Quarterly inspection results will be reviewed during the safety portion of each monthly QWAPI meeting until substantial compliance is confirmed. 4. Completion Date: 10/13/2026.	11/01/2026.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A139	A. BUILDING B. WING	09/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
E0000	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 on 9/15/26. Flandreau Santee Sioux Tribe Care Center was found in compliance.	E0000		

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 reverse for further 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
[signature]	Administrator	10/13/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/15/26 through 9/17/26. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirement: F684. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/15/26 through 9/17/26. The areas surveyed were sufficient staffing regarding staff competency, potential uncertified staff, missing medication, and resident quality of care regarding bathing, weight loss, worsening pressure ulcers, accidents and fall prevention, repositioning, and potential resident abuse. Flandreau Santee Sioux Tribe Care Center was found not in compliance with the following requirements: F684 and F755.	F0000		
F0684 SS = E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, call light audit review, and policy review, the provider failed to ensure the staff promptly resdponded to resdients' activiated call lights to meet the needs of seven of eight sampled residents (7, 9, 16, 20, 22, 23 and 56) who reported dissatisfaction with waiting for long periods of time for the staff to respond to their call lights to assist the residents.	F0684	**1. Corrective Action for Affected Residents** • **Immediate Response Fixes:** The facility immediately audited all active patient care areas to ensure all residents have a fully functioning call light within reach. Any broken call light cords identified during initial sweeps were tagged and replaced immediately by maintenance. • **Staff Alignment:** The Director of Nursing (DON) or designee immediately completed direct, individual follow-ups with nursing staff identified as having response times exceeding 10 minutes to address immediate care gaps. **2. Identification of Other Residents Potentially Affected** • **Risk Assessment:** All residents residing in the facility have the potential to be affected by delayed call light response times. • **Equipment Audit:** A facility-wide sweep was conducted to identify any additional broken call light cords or malfunctioning staff pagers. Devices not working correctly were pulled from circulation for repair or replacement to ensure adequate inventory. **3. Systemic Changes (Measures to Prevent Recurrence)** To address the lack of standardized training, orientation gaps, and the PIP-identified root causes (uncleared pagers, missing equipment, and shared devices), the following systems have been implemented: • **Standardized Training & Orientation:** ○ The facility developed and launched a standardized training and education curriculum regarding call light responsiveness and pager management. ○ This training has been integrated into the standardized orientation process for all incoming nursing, Certified Nursing Assistant (CNA), and Health Unit Coordinator (HUC) staff.	

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 reverse for further 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
[signature]	Administrator	10/13/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 1 Findings include: 1. Observation and interview on 9/15/26 at 10:22 a.m. with resident 23 in her room revealed that she was sitting in her wheelchair working on beadwork. She stated that the scheduled night shift staff was not good at responding to her call light promptly. 2. Review of resident 23's EMR revealed she admitted to the facility on 7/23/24. She had diagnoses of morbid (severe) obesity due to excess calories, nonpressure chronic ulcer of unspecified part of left lower leg with unspecified severity, paranoid schizophrenia (a chronic brain disorder with symptoms of paranoia), chronic kidney disease, stage 4, and low back pain, unspecified. Her revised 6/29/26 care plan indicated substantial/maximal assist with transfers to chair/bed to chair and sit to stand. 3. Review of resident 23's call light times from 8/17/26 to 9/16/26 revealed 97 call light times of 20 minutes or more, with the longest call light being 249 minutes and 16 seconds. 4. Observation and interview on 9/15/26 at 2:00 p.m. with resident 7 in her room revealed she was seated in her wheelchair and that the staff responded to her call light, but it could take up to an hour for them to help her. She stated it didn't matter if it was the scheduled day or night shift staff. 5. Review of resident 7's EMR revealed she admitted to the facility on 7/18/25. She had diagnoses of type 2 diabetes mellitus with diabetic chronic kidney disease, dependence on renal dialysis (medical treatment that filters waste, extra fluid and salt from the blood), and charcot's joint (A progressive degeneration of a weight-bearing joint caused by a loss of sensation and nerve damage), right ankle and foot. Her revised 6/26/26 care plan indicated substantial/maximum assist of 1-2 staff with all transfers. 6. Review of resident 7's call light times from 8/17/26 to 9/16/26 revealed 49 call light times of 20 minutes or more, with the longest call light time being 137 minutes and 13 seconds.	F0684	• **CNA Rounding & Toileting:** ○ Proactive CNA rounding and structured toileting programs have been implemented facility-wide. ○ Compliance with these rounds is documented as a mandatory line item on the updated CNA Shift Checklist. • **Strict Pager Accountability System:** ○ **Shift Launch:** All call light pagers must be individually signed out from the on-duty nurse at the start of each shift and verified on the CNA Shift Checklist. ○ **Shift Closure:** All pagers must be cleared of alerts and physically turned back into the on-duty nurse prior to the staff member clocking out. This eliminates the practice of pagers leaving the floor or being shared across shifts. ○ **Real-Time Corrections:** The HUC will audit the pager sign-in sheet against the active daily schedule. If a staff member has not signed out a pager, the Concierge will immediately deliver a functioning pager to them on the floor. **4. Monitoring & Quality Assurance (QA Oversight)** • **Daily Report Reviews:** The HUC will extract and review the automated daily call light response reports. Every instance of a call light response time exceeding **10 minutes** will be documented in a daily summary email and reported directly to the DON. • **Administrative Follow-Up:** The DON or designee will review the HUC daily reports and conduct targeted follow-up coaching with responsible staff members to address long response times. • **QA Committee Reporting:** The data compiled from the HUC audits, daily reports, and pager sign-out logs will be summarized and presented by the DON to the Quality Assurance and Performance Improvement (QAPI) / PIP Subcommittee monthly for six consecutive months. The committee will determine if further systemic adjustments or extended monitoring are required b on benchmark trends.	October 31, 2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 2 7. Observation and interview on 9/15/26 at 3:47 p.m. with resident 9 in her room revealed that she had to wait a long time for the staff to help her get out of bed in the morning. She waited 30 to 45 minutes on multiple occasions. The staff had told her to relieve herself in her incontinence brief (highly absorbent garments designed to manage heavy urinary or fecal incontinence) because they did not have time to help her. She stated she felt angry and embarrassed that the staff had said that to her. 8. Review of resident 9's electronic medical record (EMR) revealed she admitted to the facility on 6/11/26. She had diagnoses of diffuse traumatic brain injury (widespread damage to the brain's long nerve fibers caused by rapid shaking, spinning, or twisting of the head) with loss of consciousness of unspecified duration and hemiplegia (a neurological condition that causes total or partial paralysis on one side of the body), unspecified affecting left nondominant side. Her 6/17/26 care plan indicated a full mechanical lift with two staff assistance for transfers. 9. Review of resident 9's call light times from 8/17/26 to 9/16/26 revealed 62 call light times of 20 minutes or more, with the longest call light being 65 minutes and 30 seconds. 10. Observation and interview on 9/15/26 at 3:09 p.m. with resident 20 in his room revealed that he had waited over an hour for the staff to respond to his bathroom call light in the past while he was on the toilet. He did not use his call light anymore because it was not worth waiting for someone to answer it. He stated that he felt sorry for the residents that depended on the staff to go to the bathroom. 11. Review of resident 20's EMR revealed he admitted to the facility on 5/4/26. He had diagnoses of vascular dementia (a decline in thinking and memory skills), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, Unspecified diastolic (congestive) heart failure, persona history of transient ischemic attack (TIA) (a temporary blockage of blood flow to the brain), cerebral infarction (an ischemic stroke where an area of brain tissue dies) without residual deficit, and vascular dementia, unspecified severity, with other behavioral	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 3 disturbance. His revised 8/19/26 care plan indicated he was independent with toilet transfers and chair//bed to chair transfers. 12. Review of resident 20's call light times from 8/17/26 to 9/16/26 revealed only one call light time was recorded on 8/17/26 for 7 minutes and 1 second. 13. Interview on 9/16/26 at 2:53 p.m. with certified nursing assistant (CNA) O revealed she used to use a "beeper" (a small wireless device that receives and displays short messages or alerts) for resident call light notification, but it didn't work anymore. Now she looked at the call light panel at the nurses' station to know when the residents activated their call lights. The nurses responded to the residents' call lights if she was busy in another resident's room providing resident care. 14. Observation and interview on 9/16/26 at 3:55 p.m. with CNA F and CNA E revealed there was no set time that the staff were expected to respond to the residents' call lights, but the staff were to respond to the call lights as quickly as they could. There were only two CNAs assigned to work in the 200 wing. Some of the residents who resided in that wing needed the assistance of two staff members which made it hard to respond to other residents' call lights when the CNAs were working with those residents. CNA E stated the 200 wing a monitor placed at the nurses' station that would show when a resident activated their call light. The staff could monitor the call lights better with the monitor than when they used the beepers. CNA F indicated that the nurses did not help answer the residents call lights. 15. Observation on 9/17/26 at 8:02 a.m. at the 200 wing nurses' station revealed that the call light monitor indicated that resident 16's bedroom call light was on since 7:16 a.m., and resident 9's bedroom call light was on since 7:31 a.m. 16. Observation and interview on 9/17/26 at 8:23 a.m. with resident 16 in the dining room revealed she came out to breakfast at 8:10 a.m. She was an assist of one with all transfers. Her call light was on while she was in the dining room. She was unaware that her call light was still on. She stated the staff must have forgotten to turn it off when they helped	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 4 her get dressed for the day. 17. Interview on 9/17/26 at 8:26 a.m. with CNA G revealed she had gone into resident 16's room and helped her get dressed about 7:35 a.m. She thought she had turned the call light off. She thought resident 16 may have turned the call light back on. She stated she tried to respond to the call lights within five minutes of them being turned on. When she bathed residents the call lights could be on longer because she had to finish the bath before she could respond to another resident's call light. The staff used to use beepers to answer call lights, but now they relied on the monitor at the nurse's station to notify them when a resident's call light was activated. 18. Interviews on 9/17/26 at 10:00 a.m. at the resident council meeting revealed there were call light concerns. Resident 16 stated it could take up to an hour for the staff to respond to her call light. Resident 56 thought the call light system wasn't working correctly because it shouldn't take the staff that long to respond to a call light. 19. Observation and interview on 9/17/26 at 11:00 a.m. in the 200 wing revealed that the call light monitor at the nurse's station showed resident 22's call light was turned on at 10:21 a.m. Resident 22 stated that she needed to use the bathroom. She was uncomfortable waiting that long to use the bathroom. She thought the CNAs were helping another resident at that time. She felt that she has had to wait a long time for the staff to respond to her call light on a regular basis. 20. Interview on 9/17/26 at 11:03 a.m. with CNA E revealed he was going into resident 22's room to respond to her call light. He was giving a bath to resident 9 with CNA F, and they needed to complete that task before he could respond to another resident's call light. He confirmed there were two CNAs on the 200 wing for that day shift. 21. Interview on 9/17/26 at 12:59 p.m. with contracted travel registered nurse (RN) C revealed that there was a beeper on the kitchen counter that CNAs used as an audible notification for when a resident's call light was activated. He thought most of the time the CNAs looked at the monitor at the nurses station to monitor and respond to the	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 5 residents' activated call lights. He confirmed that two CNAs and one nurse were working in the 200 wing that day. The mornings were very busy, and the CNAs usually worked together to help the residents with getting up and dressed for the day. He explained that he might completing a treatment for a resident when another resident's call light was activated and knew that resident might have to wait until the staff were available to help them. He thought that the goal was for the staff to respond to the residents' call lights as quickly as possible, but sometimes there was not enough staff to do that as quickly as they would like to. 22. Interview on 9/17/26 at 2:07 p.m. with director of nursing (DON) B revealed that she had completed some in-services and education with all staff members that they were expected to respond to residents' activated call lights promptly. She expected the nursing staff to complete rounding (a proactive, structured practice where nursing staff check on residents at regular intervals) every two hours, and increases to every hour for residents with risks for falling. A monitor was added at both nurses' stations to help the staff respond to call lights promptly. She expected the staff to respond to activated call lights promptly, which she defined as within five minutes of its activation. All staff members, including nurses and CNAs, were educated to respond to the residents' activated call lights. She agreed that 20 minutes was too long for a resident to wait for staff assistance after the resident activated a call light. 23. Interview on 9/17/26 at 2:43 p.m. with interim administrator A revealed she was aware that call light response times were an issue. She expected the staff to respond to the residents' call lights within 15 minutes. Restorative aides, medication aides, and nurses were expected to help the CNAs respond to the residents' activated call lights. She agreed 20 minutes was too long for the residents' activated call lights to be responded to by the staff. 24. Review of the provider's 5/6/26 Call Light Accessibility and Timely Response policy revealed that, "The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. 10. All staff members who see or hear an activated call light are	F0684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 6 responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified." B. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure the nursing staff followed physician's standing orders (pre-approved protocols signed by a physician authorizing nurses to perform specific medical care such as administering treatments to eligible patients without needing a case-by-case order from a physician) for managing one of one sampled resident's (3) elevated temperature and decreased oxygen level by one of one contracted travel licensed practical nurse (LPN) (L) who did not promptly administer fever-reducing medication and supplemental oxygen according to those standing orders to the resident who was later transported to the emergency department. 1. Review of the provider's 7/13/26 SD DOH FRI revealed that on 7/11/26 at 5:52 p.m., contracted travel LPN L documented that resident 3 "complained of feeling as though she is burning up and has chills all over her body." LPN L obtained resident 3's vital signs (measurement of the body's basic functions) at 3:00 p.m. and the resident had a temperature of 105.0 degrees Fahrenheit (F) and an oxygen saturation (blood oxygen level) of 79% (percent) on room air. No treatment for her fever or her hypoxia were initiated. The resident then requested Tylenol (pain reliever and fever reducer). Contracted travel LPN L administered the Tylenol to the resident and obtained another set of the resident's vital signs which indicated her temperature was 103.9 F and her oxygen saturation was 84% on room air (without supplemental oxygen). Contracted travel LPN L then reported the resident's vital signs to the on-call physician. The resident was then transported to the emergency department for treatment of her fever an foul-smelling urine. Resident 3 returned to the facility after receiving treatment in the emergency department. 2. Review of resident 3's electronic medical record (EMR) revealed that her admission date was 8/12/24 and her BIMS (Brief Interview for Mental Status) score was 13 (indicating she was cognitively intact). Her medical diagnoses included paraplegia (partial or complete paralysis of the lower half of the body, including both legs, caused by damage to the spinal cord).LPN L documented in a progress note on	F0684	1. Corrective Action for Affected Residents • Immediate clinical assessment of Resident 3 was performed at the emergency department. • The contracted travel Licensed Practical Nurse (LPN) L involved in the incident was removed from providing care at this facility. 2. Identification of Other At-Risk Residents Risk Assessment: All residents residing in the facility have the potential to be affected by to lack of following standard orders. 3. Systemic Changes / Measures to Prevent Recurrence • Policy & Accessibility Update: The Medical Director's *Physician's Standing Orders* (last signed 1/18/24) and the *Oxygen Administration Policy* (revised 5/6/26) were reviewed and remain clinically sound. To eliminate access barriers identified during staff interviews, copies of the standing orders were more clearly marked. • Staff Re-Education: The Director of Nursing and/or designee initiated mandatory re-education for all licensed nursing personnel (including all permanent, contracted, and travel RNs and LPNs, specifically referencing the roles of RN N and RN C). The training covers: ○ Strict adherence to the Medical Director's standing orders, specifically the immediate administration of acetaminophen for fevers and supplemental oxygen at 2L/min via nasal cannula for an oxygen saturation below 90% prior to or concurrent with physician notification. ○ The *Oxygen Administration Policy* protocols for emergency initiation of oxygen therapy by an RN or LPN.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 7 7/11/26 that resident 3's temperature was 105.0 degrees at 3:00 p.m. Resident 3's medication administration record (MAR) indicated that Tylenol was administered at 4:46 p.m. There was no documentation in the resident's EMR that indicated oxygen was administered to the resident. 3. Interview on 9/16/26 at 2:45 p.m. with contracted travel registered nurse (RN) N revealed she thought that there were physicians' standing orders to follow for residents with conditions such as fevers or low blood oxygen levels, but was not sure where to find them. She reported that if she had a resident that she thought needed immediate treatment and she did not have a physician's order to follow in response to that resident's condition, she would call AVEL (a contracted physician service available at anytime via camera service). 4. Interview on 9/16/26 at 2:55 p.m. with contracted travel RN C revealed that he was unsure if there were physician's standing order available, but if a resident was experiencing low blood oxygen levels, he would first administer oxygen to that resident, and then would contact a physician for an order for the oxygen. 5. Interview on 9/17/26 at 10:20 a.m. with director of nursing (DON) B revealed that the facility had physician's standing orders for the nursing staff to utilize. She stated that those standing orders were posted in the locked medication rooms in each unit. She expected was staff to follow those standing orders to treat conditions such as fevers and low blood oxygen levels, then notify the physician after providing those standing order treatments. 6. Review of the provider's physician's standing orders signed by medical director M on 1/18/24 revealed that for a patient with a fever, the nursing staff were authorized to administer acetaminophen (a fever reducing medication). For a resident with an oxygen saturation below 90 %, those standing orders authorized the staff to administer oxygen to the resident at a rate of 2 liters per minute via a nasal cannula (a flexible plastic tube that delivers supplemental oxygen straight into the nose through two small prongs). 7. Review of the provider's 5/6/26 Oxygen Administration policy revealed "Oxygen is	F0684	○ The location, availability, and mandatory utilization of the AVEL camera system for immediate clinical support when a physician is not immediately reachable. • Agency/Travel Staff Onboarding: The facility's agency onboarding checklist was updated to mandate that 100% of incoming contracted travel nurses are physically shown the exact location of the physician's standing orders and emergency protocols prior to administering care on their very first shift. 4. Ongoing Performance Monitoring (QA Process) • The Director of Nursing (DON), or clinical designee, will conduct targeted audits of 6 resident records per week across all units to review instances of elevated temperatures or decreased oxygen levels. The audits will verify that standing orders were followed promptly, emergency oxygen was initiated if saturation fell below 90%, and documentation matches the clinical events. • These audits will continue weekly for 12 weeks. If 100% compliance is maintained, auditing will transition to monthly for an additional 3 months. • All audit findings will be presented quarterly to the Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator and attended by the Medical Director, for systemic trend analysis and final directive changes if compliance falls below 100%.	10/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0684 SS = E	Continued from page 8 administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. 'Oxygen therapy' is the administration of oxygen at concentrations greater than that in ambient air (20.9%) with the intent of treating or preventing the symptoms and manifestations of hypoxia (hypoxia means decreased perfusion of oxygen to the tissues). Oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control. Personnel authorized to initiate oxygen therapy include physician, RNs, LPNs, and respiratory therapists."	F0684	**1. Corrective Action for Affected Residents** • **Immediate Intervention:** Staff Member I was immediately restricted from having any nursing or medication administration assignments following the conclusion of their shift on **12/28/2025**. • **Clinical Review:** A clinical review was conducted for the **18 residents** who received medications from Staff Member I on **12/27/2025** and **12/28/2025** to ensure no medication errors or adverse reactions occurred. (Note: One resident was unaffected as their medications are exclusively nurse-administered). • **Disciplinary Action:** Staff Member J was **terminated** for failing to report the unauthorized medication administration in a timely manner. Staff Member I received final written disciplinary action due to the severity of the infraction.	
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F0755	**2. Identification of Other Potentially Affected Residents** • **Scope of Impact:** Because medication administration affects the majority of the building, all **18 out of 19 current residents** were identified as having the potential to be affected by staff members with expired credentials. • **Credential Audit:** A full audit of all current nursing and medication aide staff licenses and certifications was completed to ensure 100% compliance and that no other staff members with expired credentials were providing direct care. **3. Systemic Changes / Measures Put into Place** • **Quick Reference System:** In **January 2026**, the facility implemented a centralized, quick-reference tracking system for all staff licenses and certifications. • **Proactive Notifications:** A new notification protocol was established. Management now actively alerts employees **60 days prior** to the expiration date of their license or certification to ensure timely renewal. • **Staff Re-entry Protocol:** Staff Member I was not permitted to return to nursing or medication duties until they successfully completed recertification and retraining, which was finalized within **10 days** of the infraction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	909 JONES DR , FLANDREAU, South Dakota, 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
F0755 SS = D	Continued from page 9 This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, and policy review, the provider failed to ensure residents' medications were administered by a staff member authorized to do so by SD law regarding one of one certified nursing assistant (CNA)/medication aide (MA) I who administered medications to 18 of 19 residents after her medication aide registration expired. Findings include: 1. Review of the provider's 12/30/25 SD DOH FRI received on 12/30/25 revealed that on 12/27/25 and 12/28/25, CNA/CMA I administered medications to 18 of 19 residents after her medication aide registration expired CMA certificate. Registered nurse (RN) J was the nurse working on those days and was aware that CNA/MA I's medication administration registration had expired but allowed CNA/MA I to administer residents' medications. RN J did not report to the facility's management that CNA/MA I had administered medications with an expired registration until the end of the 12/28/25 day shift. 2. Interview on 9/16/26 at 11:05 a.m. with CNA/MA I revealed that she usually worked as a health unit coordinator (HUC) and did not usually administer medications to the residents. She reported that 12/27/25 and 12/28/25 were weekend days and she did not realize that her medication aide registration had expired. She said that she administered medications to the residents during the entire shift that she worked on 12/27/25 not knowing her registration had expired. She stated that on the morning of 12/28/25, RN J told CNA/MA I that her registration had expired but told her to pass the residents' medications anyway. CNA/MA I received disciplinary action by interim administrator A and renewed her medication aide registration following the incident. 3. Interview on 9/17/26 at 8:50 a.m. with interim administrator A revealed that following the two days that CNA/MA I administered medications to residents with an expired medication aide registration, RN J admitted t khat she knew on 12/28/25 that CNA/MA I's medication aide registration had expired. Interim administrator A reported that RN J did not seem to be concerned about delegating medication administration to CNA/MA I while knowing her registration was	F0755	**4. Monitoring and Quality Assurance (QA)** • **Monthly Audits:** The Director of Nursing (DON) or HR designee will conduct **monthly audits** of the employee credential tracking system to verify all active working staff maintain current, valid certifications. • **QA Reporting:** Audit findings and compliance data will be presented to the Quality Assurance Performance Improvement (**QAPI**) Committee monthly for ongoing review and to determine the need for further intervention. 10/31/26 January 31, 2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLANDREAU SANTEE SIOUX TRIBE CARE CENTER	**909 JONES DR , FLANDREAU, South Dakota, 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
F0755 SS = D	Continued from page 10 expired. Interim administrator A then reported that RN J's employment at the facility was terminated after the incident. Interim administrator A expected the nurses to not allow medication aides to administer medications with an expired registration. She also expected medication aides to not administer residents' medications while knowing that their registration had expired. 4. Review of the provider's 5/6/26 Medication Administration policy revealed "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination of infection."	F0755		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80038	A. BUILDING: _____ B. WING _____	09/17/2026

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) COMPLETE DATE
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 9/15/26 through 9/17/26. 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 healthcare personnel. All healthcare personnel must complete the orientation program within thirty days of hire and the ongoing education program annually thereafter. The orientation program and ongoing education program must include the following subjects: (1) Fire prevention and response; (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; (11) Abuse and neglect; and (12) Advanced directives. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5) and (8) to (12), inclusive, of this section. The facility shall provide additional personnel education based on the facility's identified needs.	S 206		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/9/2026

[redacted]tment of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80038	A. BUILDING: _____ B. WING _____	09/17/2026

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) COMPLETE DATE
S 206	Continued From page 1 This Administrative Rule of South Dakota is not met as evidenced by: Based on employee file review, interview, and policy review, the provider failed to ensure that one of five employees reviewed (H) completed the required annual training. Findings include: 1. Review of employee H's employee record revealed she was hired at the facility as a registered nurse (RN) on 5/21/25. She did not complete any of her 2026 required annual training. 2. Interview on 9/17/26 at 11:30 a.m. with human resources (HR) D regarding staff education revealed that she was responsible for assigning and monitoring the staff members' training to ensure it was completed. RN H was a PRN (as needed) staff member who only worked on occasion. HR D monitored the staff education that was assigned and completed through the RELIAS education system. HR D confirmed RN H had not completed any of the annual training in the last year. She expected all staff to complete the required annual training. 3. Interview on 9/17/26 at 2:43 p.m. with administrator A revealed that all staff were assigned annual training. She expected all staff to complete the required annual training as it was assigned. 4. Review of the provider's revised 3/31/25 Employee Education policy revealed, "All personnel of the Flandreau Santee Sioux Tribe Care Center must participate in initial orientation and regularly scheduled in-service training	S 206	1. Corrective Action for Cited Findings & Identification of Affected Residents/Staff • The facility immediately audited the training records of the specific personnel identified in the citation. Staff Member H has not worked in the facility since April 29, 2026, and will not work in the facility until education is completed. • Any identified staff member missing mandatory training modules --specifically covering topics (1) through (12) required by ARSD 44:73:04:05 --were immediately removed from direct care or scheduled duties until they completed the deficient modules. All required modules will be successfully completed and documented on or before November 1, 2026. • The Human Resources (HR) Director and/or designee conducted a 100% audit of all current personnel files on October 7-9, 2026, to ensure that all healthcare personnel hired within the last 12 months completed their formal orientation within 30 days of hire. • The audit also reviewed all existing staff files to verify that annual ongoing education covering all 12 mandatory core subjects was fully up to date. Any staff member found to have a gap was scheduled for immediate remedial training, which was completed within 7 business days of audit identification. 2. Systemic Changes to Achieve Sustained Compliance • Process Revision: The facility has overhauled its onboarding and tracking system. The facility implemented a centralized Electronic Learning Management System (LMS) through Relias that automatically locks in the 12 mandatory training subjects required by state regulation with is monitored every 30 days. • Policy Update: The facility's "Personnel Training and Orientation Policy" was updated to state that any employee who fails to complete orientation within 30 days of hire, or annual training by their deadline, will be automatically suspended from the active schedule until compliance is achieved. • Staff Re-education: The HR Director and Facility Administrator conducted a mandatory training session for all Department Heads regarding the new tracking system, suspension policy, and strict 30-day/annual timelines.	11/01/2026

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	80038	A. BUILDING: _____ B. WING _____	09/17/2026

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) COMPLETE DATE
S 206	Continued From page 2 classes."	S 206	3. Monitoring Performance & Quality Assessment (QA) Integration • The Orientation Compliance Report (showing hire date vs. orientation completion date for all new hires). • The Annual Education Tracker (showing employee roster, completion status of all 12 mandatory core subjects, and upcoming due dates). • Any system-generated alerts or policy enforcement actions taken for overdue training. • The Human Resources Director and/or designee will be directly responsible for pulling reports, conducting physical double-checks of digital logs, and executing the audits. • Audits will be conducted weekly for the first 3 months to closely monitor all new hires and upcoming annual renewals. If 100% compliance is sustained for 3 consecutive months, the auditing frequency will transition to monthly for an additional 9 months. • This structured monitoring will take place for a total duration of 12 months. After 12 months, the Quality Assurance and Performance Improvement (QAPI) Committee will determine if monitoring can be reduced to a quarterly maintenance schedule.	