STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433448	A. BUILDING _____ B. WING _____	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD IPSWICH CLINIC	110 5TH AVENUE IPSWICH, SD 57451

(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
J 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 491, Subpart A, requirements for rural health clinics, was conducted on 11/12/24. Sanford Ipswich Clinic was found not in compliance with the following requirement: J161.	J 000	Biennial Chart Review Documentation On 11/21/24, Clinical Nursing Supervisor and Clinic Director met with primary APP, nursing staff, and all other staff at Ipswich Clinic to review steps that will be completed for review of closed chart, per Sanford Policy: Rural Health Clinic Periodic Review of Health Records and Biennial Total Program Review – Enterprise. 5 random charts per month will be selected by Ipswich clinic nursing staff. Physician will review for the following parameters: - utilization of services was appropriate -plan of care was appropriate Nurse supervisor and/or clinic director will review for -staff followed Enterprise Ambulatory Clinic policies and workflows during visit These chart reviews will begin in November 2024 and be ongoing, with cumulative review and final analysis at each Annual Meeting.	11/21/24
J 161	PROGRAM EVALUATION CFR(s): 491.11(a)-(c) § 491.11 Program evaluation. (a) The clinic or center carries out, or arranges for, a biennial evaluation of its total program. (b) The evaluation includes review of: (1) The utilization of clinic or center services, including at least the number of patients served and the volume of services; (2) A representative sample of both active and closed clinical records; and (3) The clinic's or center's health care policies. (c) The purpose of the evaluation is to determine whether: (1) The utilization of services was appropriate; (2) The established policies were followed; and (3) Any changes are needed. This STANDARD is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to include a review of closed charts in the clinic's annual evaluation of services to assess the clinic's overall program	J 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Nicole Sumner, Director Clinic Sanford Aberdeen & Ipswich 11/26/24

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	433448	A. BUILDING _____ B. WING _____	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD IPSWICH CLINIC	110 5TH AVENUE IPSWICH, SD 57451

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J 161	Continued From page 1 and to identify areas needing improvement. Findings include: 1. Review on 11/12/24 at 2:05 PM of the clinic's annual evaluation revealed: *The medical director had reviewed a minimum of ten active patient charts each month. *The Quality Control nurse had reviewed active patient charts to review specific quality markers each month. *There was no documentation that indicated closed charts had been pulled for review. Interview on 11/12/24 at 2:05 PM with clinic director A revealed: *She confirmed active patient charts had been reviewed monthly as part of their annual clinic evaluation. *She confirmed closed patient charts had not been included in the annual clinic evaluation of services. *She was unaware that a review of closed patient charts was required. Review of the provider's Program Evaluation policy revealed, both open and closed charts were to be reviewed as part of the program evaluation.	J 161		

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SANFORD IPSWICH CLINIC	110 5TH AVENUE IPSWICH, SD 57451

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 491.12, Subpart A, Emergency Preparedness requirements for rural health clinics, was conducted on 11/12/24. Sanford Ipswich Clinic was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Nicole Sumner, Director Clinic Sanford Aberdeen & Ipswich 11/26/24

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