

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10558 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2024
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH RAPID CITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 353 FAIRMONT BLVD POST OFFICE BOX 6000 RAPID CITY, SD 57701		
(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 complaint health survey for compliance with the Administrative Rules of South Dakota, Article 44:75, Hospital, Specialized Hospital, Critical Access Hospital, and Rural Emergency Hospital Facilities, was conducted from 4/3/24 through 4/4/24. Areas surveyed included patient abuse, nursing services, patient rights, and quality assurance. Monument Health Rapid City Hospital was found not in compliance with the following requirement: S115.	S 000		
S 115	44:75:01:07 Reports to Department Each facility shall report any of the following events to the department through the department's online reporting system within twenty-four hours of the discovery of the event: (1) Any incident or event where there is reasonable cause to suspect abuse or neglect of any patient by any person; (2) Any death resulting from other than natural causes originating on facility property; (3) A missing patient; (4) A fire in the facility; (5) Any loss of utilities, emergency generator, fire alarm, sprinklers, and other critical equipment necessary for operation of the facility for more than 24 hours; or (6) Any unsafe water samples for pools or spas. The facility shall conduct an internal investigation for the event and report the results to the department no later than five working days after the event. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, record review, and policy	S 115	Director of Quality, Safety, & Risk Management and Legal reviewed Reportable Cases and Serious Adverse Events Policies. Director of Quality, Safety, & Risk Management reviewed Department of Health documents: Fall Reporting Requirements and Reporting of Injuries of Unknown Source and Reasonable Suspicion of a Crime. Director of Quality, Safety, & Risk Management worked with the Department of Health Complaint Advisor to gain understanding of reportable incidents including patient to patient altercation resulting in law enforcement notification and falls with serious bodily injury. Education was developed regarding the necessity of regulatory reportable incidents to include patient to patient altercation resulting in law enforcement notification and falls with serious bodily injury. Education will be completed by all Rapid City Hospital Safety and Risk Management Caregivers and Rapid City Hospital Executive Leadership Team by May 3, 2024. Safety and Risk Management caregivers on leave will be required to completed education prior to the first worked shift. Department Director or designee will monitor education completion	05/19/2024

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

TITLE

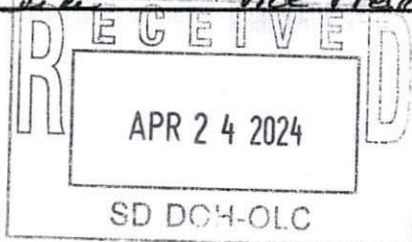
(X6) DATE

STATE FORM

6899

7N111

If continuation sheet 1 of 5



Glenn Linn Vice President Quality, Safety, Risk Management 4/24/24

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10558 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2024
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH RAPID CITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 353 FAIRMONT BLVD POST OFFICE BOX 6000 RAPID CITY, SD 57701		
(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	Continued From page 1 review, the provider failed to ensure a report with a thorough investigation was submitted to the South Dakota Department of Health (SD DOH) for the following: *A physical altercation between two of two sampled patients (1 and 7) that required police involvement, and an arrest. *An unobserved fall with a head injury for one of one sampled patient (4) that required emergency medical treatment. Findings include: 1. Interview and closed record review on 4/3/24 at 3:00 p.m. with registered nurse (RN) L of patient 1's psychiatric discharge summary on 3/12/24 revealed: *She was admitted to the facility on 12/31/23 for an involuntary psychiatric hold. *She was diagnosed with the following: psychotic disorder; mania; depressive disorder; passive suicidal ideations; schizoaffective disorder, bipolar type; PTSD (post-traumatic stress disorder); assaultive behavior; antisocial personality disorder; and substance abuse. *On 3/12/24 she: -Was accepted at another psychiatric hospital and was awaiting transportation. -Physically assaulted another female patient (7) when she grabbed the patient's lunch tray and threw it to the floor, grabbed the patient, pushed her, and pulled her hair. -Stated to staff that she was going to repeat that behavior until she went to jail. *RN L stated she was aware of the incident and the staff had to physically separate patient 1 from patient 7. -Patient 7 decided to press assault charges and patient 1 was arrested, discharged from the hospital, taken into police custody, and transported to jail.	S 115	Continued From page 1 and report to the Vice President of Quality, Safety, & Risk Management by May 3, 2024. Monitoring: Department Director or designee will review all falls with serious bodily injury and all patient to patient altercation with law enforcement notification for appropriate mandatory reporting. Monitoring will continue until 100% compliance has been sustained for 3 consecutive months. Results will be reported monthly to the Vice President of Quality, Safety, & Risk Management and Rapid City Hospital Executive Leadership Team.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10558 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2024
--	--	--	---

NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH RAPID CITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 353 FAIRMONT BLVD POST OFFICE BOX 6000 RAPID CITY, SD 57701
--	---

(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>Review of the provider's 3/12/24 'Patient Event' report had listed the above occurrence as a violent security incident lasting about ten seconds in length involving physical violence between two patients. The report indicated it was determined to be an unprovoked attack on patient 7. Patient 7 was assessed by staff for injury following the attack and she denied any physical injuries.</p> <p>Interview on 4/4/24 at 9:20 a.m. with the director of quality, safety, and risk management (QSRM) F regarding the SD DOH incident report revealed law enforcement had been notified of the event, but the SD DOH was not notified because staff had determined there was no patient injury.</p> <p>Interview on 4/4/24 at 11:21 a.m. with the director of behavioral health A regarding the above event revealed it was his expectation that a thorough investigation and report should have been submitted to the SD DOH.</p> <p>2. Review of resident 4's electronic medical record (EMR) revealed: *Her admission date was 3/25/24. *The resident was transferred to the emergency department (ED) for medical treatment after a fall on 3/27/24 and returned to the facility later that same day.</p> <p>Review of the provider's list of serious occurrences between 12/1/23 and 4/3/24 revealed: *On 3/27/24 patient 4 was found on the bathroom floor by staff after she was heard calling out. -She was "bleeding profusely" from a cut on her face. *The patient became dizzy while walking to the bathroom, "fell, and hit her face on the toilet sit</p>	S 115		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10558 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/04/2024
--	---	---	---

NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH RAPID CITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 353 FAIRMONT BLVD POST OFFICE BOX 6000 RAPID CITY, SD 57701
---	---

(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 3</p> <p>[seat]".</p> <p>-She sustained a laceration "3 cm [centimeter] long and 2 mm [millimeter]deep in between her eyebrows extending close to the bridge of her nose".</p> <p>**Assessment: Patient bleeding from the injury site, she appears lethargic".</p> <p>*The clinical resource nurse and a medical practitioner were notified of the resident's unwitnessed fall.</p> <p>*Emergency medical services was called and the patient was transported to the local ED for treatment.</p> <p>A copy of the facility's report to the SD DOH regarding the event referred to above was requested on 4/4/24 at 8:35 a.m. from accreditation specialist B.</p> <p>Interview on 4/4/24 at 9:20 a.m. with the director of QSRM F regarding the above incident revealed:</p> <p>*The fall was not reported to the SD DOH.</p> <p>-After an internal review of the event it was determined "There were no process failures with patient 4".</p> <p>Review of the revised March 2024 Serious Adverse Events policy revealed:</p> <p>**1. Serious Adverse Event: A serious adverse event is an unanticipated adverse event with one or more of the following outcomes:" "b. Required or prolonged hospitalization,"</p> <p>**4. Refer to "Reportable Cases" Policy on appropriate agency notification."</p> <p>Review of the December 2023 Reportable Cases policy revealed:</p> <p>**1. Mandatory Report-State/Federal law requires the following be reported:"</p>	S 115		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10558 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 04/04/2024
NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH RAPID CITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 353 FAIRMONT BLVD POST OFFICE BOX 6000 RAPID CITY, SD 57701		
(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	Continued From page 4 -"a. Any incident or event where there is reasonable suspicion of abuse or neglect of any hospital patient by any person shall be reported within 24 hours of becoming informed of the alleged incident or event." -"i. For purposes of this provision, 'Abuse' means: An intentional act toward an individual indicating that one or more of the following has occurred:" -"i. a. A criminal conviction against a person for mistreatment toward an individual; or" -"i. b. In the absence of a criminal conviction, substantial evidence that one or more of the following has occurred resulting in harm, pain, fear, or mental anguish:" -"(ii) An attempt to commit a crime against a patient or resident; or" -"(iii) Physical harm or injury against a patient or resident; or" -"(iv) Using profanity, making a gesture, or engaging in any other act made to or directed at a patient or resident:"	S 115		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10558 S	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 06/24/2024
--	--	---	---

NAME OF PROVIDER OR SUPPLIER MONUMENT HEALTH RAPID CITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 353 FAIRMONT BLVD POST OFFICE BOX 6000 RAPID CITY, SD 57701
--	---

(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	<p>Compliance/Noncompliance Statement</p> <p>An onsite revisit survey was conducted on 6/24/24 for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals for all previous deficiencies cited on 4/4/24. All deficiencies have been corrected and no new non-compliance was found. Monument Health Rapid City Hospital was found in compliance with all regulations surveyed.</p>	S 000		

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