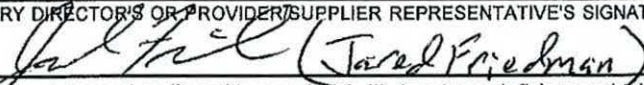


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/02/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 430016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2026
NAME OF PROVIDER OR SUPPLIER AVERA MCKENNAN HOSPITAL & UNIVERSITY HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 S CLIFF AVE SIOUX FALLS, SD 57117		
(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
A 000	INITIAL COMMENTS				
A 799	A complaint health survey for compliance with 42 CFR Part 482, Subparts A-D; and Subsection 482.66 requirements for hospitals was conducted from 3/31/26 through 4/1/26. Areas surveyed included discharge planning and patient rights. Avera McKennan Hospital & University Health Center was found not in compliance with the following requirements: A799 and A803. DISCHARGE PLANNING CFR(s): 482.43 The hospital must have in effect a discharge planning process that focuses on the patient goals and treatment preferences and includes the patient and his or her caregivers support person(s) in the discharge planning for post-discharge care. The discharge planning process and the discharge plan must be consistent with the patient's goals for care and his or her treatment preferences, ensure an effective transition of the patient from hospital to post-discharge care, and reduce the factors leading to a preventable hospital readmissions. This CONDITION is not met as evidenced by: Based on review of an anonymous complaint report received by the South Dakota Department of Health (SD DOH, record review, interview, policy review, and job description review, the provider failed to ensure one of eight sampled patients (5) discharge orders were reviewed for accuracy by one of one case manager (CM) (E) before being discharged from the facility and readmitted to an assisted living center (ALC) that could not provide him with the level of care that he needed, and he was re-hospitalized after two days.		A 799	A meeting was held on April 7th, 2026 with Accreditation, the Care Transitions Director, and the Case Management Manager to review survey findings, current policies, and staff education. During this review, gaps were identified in staff knowledge, consistency of process implementation, and alignment with CMS Conditions of Participation (CoPs). In response, the Plan of Correction includes development and revision of related policies, targeted staff education, and implementation of key process supports. A review of A-0799 (42 CFR 482.43 – Discharge Planning) was conducted, and a root cause analysis identified key breakdowns in the discharge process. These included inappropriate discharge disposition and level-of-care mismatch, as the patient was discharged to an assisted living facility that could not meet his clinical needs; failure to ensure discharge orders were fully reviewed for accuracy prior to discharge; missing or incomplete discharge medications, including omission of anticoagulation therapy from discharge instructions; and failure to order necessary post-discharge services, including physical therapy and home health services.	6/12/26

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	CMO	6/9/26

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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A 799	Continued From page 1 Findings include: 1. Review of an anonymous complaint received (time withheld due to anonymity) by the SD DOH revealed patient 5 had an increased temperature and complained of a headache and was transferred from an ALC to the local hospital's emergency department (ED) for evaluation. Through testing and assessments, it was determined that the patient had a brain bleed and required a higher level of care. The patient was air-lifted to an acute care hospital where he was admitted for further care and treatment. After patient 5 was admitted to the acute care hospital, the director of nursing (DON) G at the ALC received physician notes from the hospital to keep her informed of the patient's current condition. DON G had conversations with the patient's social worker (SW) and was concerned that they would not be able to meet his needs when he was discharged from the hospital and admitted back to their facility. He required the use of a nasal gastric (NG) tube (a small tube that is placed through the nose and down into the stomach for nutritional support), a heparin drip (blood-thinning medication administered intravenously (IV), and rehabilitation therapy needs for muscle strengthening. As an ALC, they were not able to support that level of care (LOC). On 2/11/26 CM (staff who assist patients with discharge planning) E contacted DON G regarding patient 5's status and indicated he was back to his baseline level of care before his admission and was able to be discharged back to the ALC. Again, DON G voiced her concerns that they would not be able to support his LOC needs. CM E confirmed the patient no longer had an IV	A 799	Immediate corrective actions began on April 2, 2026, when the Case Management Manager communicated preliminary survey findings and expectations to staff. Ongoing communication and education continued throughout April, including identification of gaps in discharge planning workflows, documentation practices, and policy alignment. On April 6, 2026, the Patient Discharge or Transfer to Another Acute Care Facility policy was reviewed and revised to include clear guidance for discharge documentation within the electronic medical record. All staff will be educated on the revision by June 12, 2026. In parallel, development of a comprehensive Discharge Planning policy was initiated on April 2, 2026, to establish a standardized, interdisciplinary discharge process. This policy includes early patient screening, assessment of post-discharge needs, development and reassessment of individualized discharge plans, coordination with post-acute providers, and required documentation. The policy incorporates key process supports, including the discharge checklist and escalation pathway finalized on June 3rd, 2026, and all staff education will be completed by June 12, 2026. Additional corrective actions included finalization and implementation of standardized tools on June 9, 2026, including the Case Management Discharge Checklist to Facility, Therapy Recommendation Workflow algorithm, and Discharge Escalation Pathway. These tools ensure alignment between patient needs and discharge disposition, confirmation of receiving facility acceptance, accurate medication reconciliation, and appropriate arrangement of post-discharge services. Policies related to PASRR and Discharge/Readmission Chart Audits policies were also implemented to support appropriate level-of-care decisions and ongoing evaluation of discharge planning effectiveness. Education for these policies will be completed by June 9, 2026.		

To identify other potentially affected patients, the organization will conduct retrospective and ongoing reviews of a representative sample of discharged patient records, with a focus on patients discharged to post-acute care settings and those readmitted within 30 days. These reviews will evaluate discharge disposition, accuracy and completeness of discharge orders, inclusion of medications in discharge instructions, and whether appropriate therapy and post-discharge services were arranged.

In addition, newly implemented discharge/readmission chart audits and pharmacy-led medication discrepancy tracking will be used to identify similar cases in real time. Any additional patients identified with comparable gaps will be reviewed for appropriate follow-up, including provider notification, correction of documentation if applicable, and targeted education. Trends identified through these reviews will be incorporated into ongoing performance improvement activities to ensure sustained compliance and reduce the risk of recurrence.

On April 2, 2026, the Case Management Manager provided staff with an overview of existing Case Management policies and identified gaps requiring review, updates, and clarification of ownership. This included evaluation of policies related to discharge planning, interdisciplinary rounds, and post-acute coordination, as well as identification of inconsistencies in policy structure and accessibility. This review informed the need for policy updates, consolidation, and improved accessibility to support compliant discharge planning practices.

On April 6, 2026 the Accreditation Manager met with the Director of Professional Practice to review the Patient Discharge or Transfer to Another Acute Care Facility policy and identified gaps in clarity and guidance, specifically within Section C (Procedure), which lacked detailed instructions for discharge documentation. Section C was revised the same day to include clear directions outlining steps for completing discharge documentation in the electronic medical record, improving staff guidance and documentation consistency.

Also, on April 2, 2026, the Care Transitions Director initiated development of a comprehensive Discharge Planning Policy. The policy establishes a standardized, interdisciplinary process that includes early patient screening, evaluation of post-discharge

needs, development and implementation of individualized discharge plans, ongoing reassessment, coordination with post-acute providers, and required documentation to support appropriate level-of-care placement and safe transitions of care. The discharge checklist and escalation pathway were incorporated into and linked within the policy to support consistent application and decision-making. The policy was finalized and implemented on June 5th, 2026. Email correspondence occurred throughout April 2026 to support communication and education efforts.

On April 7th, 2026, Accreditation distributed reference materials and a binder checklist to support resurvey preparation and documentation readiness.

Between 4/7/26 and 4/8/26, email correspondence occurred between the Care Transitions Director and the Director of Professional Practice regarding access and permissions to create a policy in PolicyStat.

On April 14th, 2026, Case Management communicated preliminary discharge process gaps to staff and emphasized the need for policy, process, and education improvements in anticipation of formal DOH findings.

The Patient Discharge or Transfer to Another Acute Care Facility policy reviewed during survey primarily addressed documentation workflows in Meditech. Following the organization's transition to EPIC on May 30th, 2026, the policy was revised to align with EPIC workflows and updated documentation processes, with finalization will be completed by June 9, 2026. All staff will be educated on the policy update by June 12, 2026.

As of June 5, 2026, all Case Management staff completed education on discharge planning requirements, with emphasis on CMS Conditions of Participation (CoPs) for Discharge Planning. Staff not present during the education sessions (e.g., PRN, vacation, or leave) were contacted by their leader and provided the education via telephone, with attestation completed on their behalf. Staff currently on FMLA will receive education and complete attestation upon return to work.

Changes were implemented to standardize the discharge planning process and ensure consistent, compliant practice. On June 5, 2026, the Discharge Planning policy, Discharge/Readmission Chart Audit policy, Post-

Acute Placement Concern Escalation policy, and the Preadmission Screening and Resident Review (PASRR) policy were finalized and implemented to establish clear expectations for discharge planning, documentation, and level-of-care decision-making.

A Case Management Discharge Checklist to Facility was implemented to standardize discharge practices for patients transitioning to a facility. This checklist requires verification of alignment between the patient's clinical needs and discharge disposition, confirmation of receiving facility acceptance prior to transfer, and confirmation that all required elements—including medications, treatments, therapy services, and post-acute care needs—are addressed, arranged, and documented prior to discharge.

Additionally, the Therapy Recommendation Workflow algorithm was implemented to provide a standardized, step-by-step approach to discharge planning. This tool supports decision-making based on therapy intensity, patient needs, and patient acceptance of recommendations, ensuring appropriate referrals and alignment of discharge disposition with clinical needs.

A mandatory Discharge Escalation Pathway was also implemented to guide staff in managing high-risk discharge scenarios. This includes situations in which patients are identified as high risk, receiving facilities decline acceptance, or facilities express concerns regarding their ability to meet patient care needs. The pathway requires escalation to Case Management leadership for review of the patient's clinical status, discharge plan, and communication with the receiving facility. If discharge is determined to be inappropriate, leadership collaborates with the attending provider and interdisciplinary team to reassess the discharge plan and ensure alignment with the patient's needs and available post-acute resources prior to discharge.

To support sustained compliance, on June 5, 2026 staff were educated on Preadmission Screening and Resident Review (PASRR) Policy, Discharge/Readmission Chart Audits, Day of Discharge Checklist, DOH Education including survey findings and CoP Section A-0799 482.43 and CoP Section A-0803 483.43

On June 5th, 2026 CMS CoPs for Discharge Planning – AMCK3161 education was created in HealthStreams. Staff will be assigned the education with a completion deadline of July 31,

	2026. This education will be required annually and incorporated into new hire onboarding to ensure ongoing competency and adherence to discharge planning requirements.	
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A 799	Continued From page 2 heparin drip nor an NG tube for nutritional support. On 2/16/26 CM E contacted DON G, stating patient 5 was ready to return home. DON G stated she would need to have accurate documentation that the patient was fit for the ALC to safely take care of him. CM E sent the most recent documentation from the physician to DON 5 for her to review. DON G reviewed the most recent documentation and discharge notes from the physician and agreed to accept him back into the ALC. She informed CM E that they would not be able to admit him back into their facility until the next day, on 2/17/26. He was admitted back to the ALC later that afternoon (2/16/26) without DON G's knowledge or consent. She had received a call from the ALC staff to let her know he had returned from the hospital. Upon review of his hospital discharge orders, DON G noted that he was not on any anticoagulation therapy (blood-thinning medications). She felt this was unsafe and scheduled an appointment for him to see his primary care provider (PCP) H on 2/18/26. She also noted that during his stay at the acute care hospital, he had a Preadmission Screening and Resident Review (PASRR) (an assessment completed to identify a mental health illness and to ensure the patient was placed in the appropriate setting). The PASRR results qualified him for 100 days of care in a long-term care facility (LTC). This assessment supported her concerns about the ALC not being able to meet his care needs. On 2/18/26, patient 5 complained of a headache and was unsteady on his feet. DON G		A 799	Case Management leadership will validate the use of the discharge checklist on facility discharges through ongoing auditing. 10 discharged patient chart audits will be conducted weekly, Monday through Friday, for 30 days to evaluate discharge checklist completion and accuracy, with a goal of 90% compliance. This will be followed by 5 weekly audits for 60 days, with a goal of 95% compliance. After that period, 10 audits will be conducted monthly for 3 months with a goal of 100% compliance to ensure sustained accuracy and compliance. Thereafter, 10 audits will be conducted quarterly on an ongoing basis to support continued compliance. Discharge audits will evaluate the accuracy and completeness of discharge orders, including medication reconciliation, as well as alignment of the discharge disposition with the patient's level-of-care needs. Reviews will also assess documentation confirming receiving facility acceptance and verify that all required post-discharge services, including therapies and other care needs, are appropriately arranged and documented prior to discharge. In addition, discharge checklist audits will include verification of the discharge date and completion of all required checklist elements. Identified gaps will result in immediate remediation, including documentation of the employee responsible and completion date of follow-up actions. Ongoing or repeated concerns will be addressed in collaboration with Human Resources through the corrective action process. Monitoring results will be reviewed weekly by Case Management leadership. Results and trends will be reported monthly to the Accreditation Manager and to the Quality Committee every other month beginning 7/15/26. The Quality Committee will evaluate achievement and sustained compliance over the defined monitoring period to determine whether to modify or conclude auditing activities.	

	Committee findings will be reported through established governance structures, including the Board of Directors.	
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A 799	Continued From page 3 transported the patient to a sister facility, so that the hospital could review his stay at the acute care facility. He was re-admitted to the hospital just two days post-discharge from the acute care facility. Later, he was discharged from that hospital to a LTC facility for rehabilitation care and treatment. 2. Review of patient 5's electronic medical record (EMR) from 1/26/26 through 2/16/26 revealed on 1/26/26, he was air-lifted to the facility and presented to the ED with complaints of a headache, confusion, and fever. Through assessment and testing in the ED, it was identified that he had an active brain bleed. He had a history of atrial fibrillation (irregular heartbeat) and coronary artery disease (heart condition that blocks the blood flow to the heart) with a stent (small tube inserted into the artery to improve blood flow to the heart) placement in 2021. He required the use of Warfarin (blood-thinning medication) to help regulate his heart rate and blood flow to the heart. His treatment course was complicated due to his history of alcohol consumption, smoking, community-acquired pneumonia (infection in the lungs) causing an exacerbation of his chronic obstructive pulmonary disease (COPD) (lung disease that restricts airflow), behaviors due to bipolar (mood fluctuations) diagnosis that required medication adjustments, malnutrition with NG tube placement for nutritional support, and urinary retention with a foley catheter placement (tube inserted into the bladder to assist with urine flow). His brain bleed required the use of vitamin K to	A 799			

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A 799	Continued From page 4 reverse the blood-thinning medication that he had taken at the ALC, Abilify (an antipsychotic medication) was prescribed to help with his behaviors, bipolar disorder, and increased anxiety. From 1/26/26 through 2/4/26, he was placed on bedrest and required the use of soft wrist restraints (device used to secure a patient's wrists to a bed frame) due to his having alcohol withdrawals and needed the restraints to prevent him from causing self-harm or pulling out any tubes, lines, or dressings that were required for medical treatment. He was combative, impulsive, and had aggressive behaviors, with the inability to follow directions from the staff. He had a history of falling and had two falls during his hospitalization. He was high risk for falling until due to his impulsive behaviors and poor safety awareness. His Warfarin was discontinued, and he was started on Eliquis (a blood-thinning medication) for replacement therapy during his hospitalization. Patient 5's physical therapy documentation from 1/27/26 through 2/12/26 indicated physical therapy was ordered upon admission to work on strengthening muscles to return him to his baseline. Before his hospitalization, he was independent with all activities of daily living (ADL) and medication management at the ALC. Physical therapy was unable to evaluate and treat the patient until 2/2/26 due to bed rest orders. Upon initial evaluation, the patient required the assistance of two staff members to assist with bed mobility, sitting on the edge of the bed, and control of his upper part of his body. He was	A 799			

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A 799	Continued From page 5 unable to follow verbal cues from the physical therapist. His knees buckled upon standing and required the physical therapist to support his knees while standing. With assistance, he stood for 20 seconds. By working with physical therapy, he was able to regain independence with bed mobility and transfers and needed stand-by assistance from the staff with walking. Due to continued confusion, he had difficulties with comprehension. On 2/12/26, the physical therapist indicated that the patient would benefit from continued physical therapy with home health (HH) services and required a chair alarm and items to be within his reach for fall safety. Patient 5's case management notes indicated on 1/29/26, CM E reached out to the ALC DON G to discuss the patient's baseline level of care status before 1/26/26. DON G informed CM E that at his baseline, he was independent with all ADLs, pleasant, and never combative. He was known to go out and drink alcohol and, at times, smoke marijuana (causes relaxation, euphoria, and altered perceptions, and impaired memory/coordination). He would need to return to this baseline before the ALC would accept him back. The ALC did not offer HH services. On 2/4/26, a fax was sent to the ALC that indicated the patient was unable to participate in the conversation and required 1:1 (staff sitting in the room continuously with the patient) staff supervision. Patient 5 was not medically ready for discharge and required a rehabilitation stay. On 2/9/26, CM E met with the patient at the bedside, and he continued to require 1:1 staff supervision. Patient 5's medical doctor (MD) reported that the patient was stable and could be	A 799			

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A 799	Continued From page 6 discharged from the hospital. CM E was going to start check on the facility referrals for the patient once he was off 1:1 staff supervision. On 2/10/26, CM E contacted the ALC to review patient 5's data to see if the patient was able to return to their facility. She was going to follow up with the ALC on 2/11/26 since the patient was medically ready to be discharged from the hospital and back to the ALC. On 2/11/26, CM E spoke with DON G at the ALC regarding the patient returning to their facility because he was medically ready. DON G stated the patient was not able to return to their facility due to him receiving an intramuscular injection of Zyprexa (medication used to treat mental instability, such as bipolar disorder) and required 1:1 staff supervision on 2/8/26. CM E informed DON G that patient 5 was medically ready according to the hospital physician. Both parties argued back and forth on contacting the state ombudsman (a neutral patient and resident advocate that is associated with the state social services department). On 2/16/26, CM E faxed the physician's progress note regarding patient 5 from that day to DON G at the ALC. At the same time, she requested the social worker (SW) to set up a ride for the patient and to update the facility and patient 5 when transportation was confirmed. This request was made before the ALC agreed to accept him back. Later that day, CM E received a call from DON G, who requested documentation to support patient 5 no longer needed a NG tube for nutritional support and did not require heparin injections at discharge.	A 799			

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A 799	Continued From page 7 CM E followed up with the hospital physician and requested documentation to indicate that patient 5 would not need a rehabilitation stay was okay to return to the ALC. She also requested discharge orders from the physician, and they were faxed to the ALC. She received a call from DON G stating they could take the patient back if the hospital was able to find transportation. The hospital arranged for transportation to arrive at 3:00 p.m. and transfer the patient back to the ALC via taxi services. CM E documented that she contacted the family and patient 5 about his discharge status. There was no documentation to confirm that she had followed up with the ALC to let them know transportation was arranged and that the patient would arrive at their facility later that day. Patient 5's PASRR revealed he had one completed on 1/19/26 and 2/4/26. Both PASRRs were referred to Maximus (a separate state organization that ensures appropriate placement for the patients) for further evaluation. On 2/4/26, Maximus approved the patient for 100 days of convalescent care long-term care. There was no further documentation to support that CM E had attempted to contact any LTC facilities for patient 5's placement. Patient 5's licensed social worker (LSW) D communication documentation indicated on 2/10/26, patient 5 was off 1:1 observation, physical therapy was working with the patient, a skilled nursing facility (LTC) was pending approval for placement, and the ALC was reviewing the patient's status to see if they could safely re-admit him back to the facility. On 2/12/26, patient 5 was medically ready to return to the ALC, and CM E was working with the	A 799			

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A 799	Continued From page 8 local ombudsman to coordinate his discharge from the hospital. On 2/16/26, CM E requested that transportation be arranged for the patient to be discharged from the hospital and admitted back to the ALC. LSW D requested transportation for patient 5 and notified CM E, and patient 5's bedside registered nurse (RN) that transport was expected to arrive at 3:00 p.m. that day. There was no documentation to confirm that the ALC agreed to admit the patient back into their facility and that the ALC was notified that the hospital had arranged for patient 5 to arrive at the ALC later that same day. Patient 5's 2/10/26 psychiatry progress note on 2/10/26 indicated "The patient is confused but not agitated this afternoon. He will wax/wane [fluctuate] in presentation and agitation." "Today, the patient was seen, but upon entering the room, the patient was found standing next to the bed, refusing to sit back in his bed, and is not responsive to redirection despite multiple attempts by myself and nursing staff." "Patient proceeds to become increasingly agitated and, despite multiple attempts, does not respond to verbal de-escalation and redirection." A mental status exam revealed that patient 5 was agitated, his speech was at a high volume, and he lacked insight or understanding of his illness. His judgment was poor based on his decision-making in everyday activities, social situations, compliance, and motivation for treatment. Patient 5's acute care violence assessment tool indicated on 2/12/26 that he remained confused,	A 799			

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A 799	Continued From page 9 irritable, agitated, impulsive, continued to have substance intoxication withdrawal, and he remained at high risk for causing violence. On 2/15/26 and 2/16/26, he remained confused. agitated, impulsive, continued to have substance intoxication withdrawal, and he was assessed as having a moderate risk of causing violence. On 2/12/26, the hospital physician documented that the patient was medically ready to be discharged from the hospital and readmitted back to the ALC or previous level of care and was discharged back to the ALC on 2/16/26. The hospitalist's 2/16/26 progress note for patient 5 indicated there was a discharge discrepancy. It was initially documented that the patient was medically ready to be discharged to the ALC. But at the end of the patient's review of his hospital stay, the hospitalist had documented that patient 5 was medically stable and ready for discharge to a post-acute rehabilitation facility for continued therapy. This documentation was electronically signed on 2/16/26 at 12:40 a.m. Patient 5's 2/16/26 discharge summary indicated that the documentation was started at 2:18 p.m. that day before his discharge from the hospital. His anticoagulation treatment (Eliquis) was resumed for his diagnosis of atrial fibrillation and past stent placement. There was no documentation that the hospital physician ordered HH services for physical therapy for muscle strengthening. He was medically stable and discharged to the ALC. This documentation was electronically signed on 2/17/26 at 5:47 p.m., the day after he was discharged. Patient 5's 2/16/26 discharge instructions and	A 799			

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A 799	Continued From page 10 orders that were sent with him to the ALC indicated Ellquis was not transcribed on those orders, as the discharge summary had indicated. Home health was not ordered for the patient to continue with physical therapy to help him return to his baseline level of care, where he was fully independent with all ADLs. There was no documentation to support that the interdisciplinary team (IDT) had discussed and reviewed patient's barriers to returning to a facility that did not require 24-hour licensed professional care, such as a nurse. The ALC was required to have a licensed nurse in their facility once a week. The highest level of professional medical coverage at the ALC would be a registered medication aide. The patient required assistance with ambulation and further muscle strengthening through physical therapy services. His moods continued to fluctuate due to changes in his psychotropic medications during his hospitalization. The psychologist could not complete a full assessment of him on 2/12/26 due to his increased behaviors that day. He continued to have no safety awareness with impulsive behaviors, confusion, and anxiety issues. He remained at high risk for falling upon discharge from the hospital, which increased his risk for more brain bleeds. There was no communication documented that the IDT discussed his PASRR approval for LTC services for 100 days, where there would be a licensed nurse in the facility 24-hours a day and seven days a week to ensure his safety. 3. Interview and Patient Discharge or Transfer to Another Acute Care Facility policy review on 4/1/26 at 9:00 a.m. and again at 2:55 p.m. with RN CM manager C revealed a patient was	A 799	On June 4 th , 2026, a multidisciplinary meeting was held with Pharmacy Leadership, Accreditation, Quality, Hospital Medicine, Care Transitions, Case Management, and Medical Support Services to review and address discharge processes related to medication accuracy. A gap analysis was conducted, including a review of physician and pharmacy workflows. This review identified gaps in physician workflow and electronic medical record functionality that contributed to medication discrepancies. In response, corrective actions were implemented to standardize discharge medication review and strengthen monitoring processes. Enhancements included in development of reporting capabilities within the new electronic medical record to track and trend discharge medication discrepancies. These reports incorporate key data elements, including patient identifiers and medication details, to support ongoing analysis, identification of trends, and targeted corrective actions. To achieve sustained compliance, changes have been implemented within the EPIC electronic medical record to standardize discharge medication review and improve workflow reliability. When a discharge order is entered by the provider, pharmacists are notified through multiple alerts, including a visual indicator in the Clinical Monitoring Scoring System, a consult message in their InBasket, and a Haiku push notification if they are part of the treatment team. Upon notification, the pharmacist navigates to the Discharge Navigator and selects the Discharge/Readmit workflow. They then complete a comprehensive review of medications and communicate any recommendations to the provider. If updates are needed, the pharmacist uses the "Sign and Hold" function to make changes. Finally, the pharmacist documents completion of the review by completing the "Discharge Meds Ready for Review" order within the discharge workflow. In addition, a discharge-specific "iVent" has been	6/4/26	

developed to allow pharmacists to document interventions related to discharge medication reconciliation, supporting consistent tracking and communication when provider follow-up is needed. Standardized discharge types and smart text are being implemented to reduce free-text variability and improve documentation consistency. Enhanced reporting capabilities within EPIC, including use of SlicerDicer, allow for tracking of discharge-related iVents, monitoring of pharmacist review rates, and analysis of discrepancies using defined data elements such as patient and provider information. This report will allow for the tracking and trending of physician fall outs and will be addressed by the Director of Hospital Medicine.

On June 4, 2026, providers were educated on consistent use of the discharge medication review workflow in Epic, including required use of the "pharmacy review" function during the discharge process to ensure medication accuracy prior to patient departure. This workflow did not initially capture patients discharged to a long-term care (LTC) facility or another healthcare setting. In response, on June 8th, 2026 the Chief Medical Officer, pharmacy leadership, IT leadership, and Accreditation partnered to address this gap. As a result, when a discharge order is entered, pharmacists are now notified through multiple alerts, including a visual indicator in the Clinical Monitoring Scoring System, a consult message in their InBasket, and a Haiku push notification if they are part of the treatment team. Upon notification, the pharmacist navigates to the Discharge Navigator, selects the Discharge/Readmit workflow, and completes a comprehensive medication review while communicating any recommendations to the provider. If updates are needed, the pharmacist uses the "Sign and Hold" function to make changes. Completion of the review is then documented within the discharge workflow by completing the "Discharge Meds Ready for Review" order.

Pharmacy Leadership will conduct structured audits of discharge medication orders to verify medication order accuracy, identify any physician-related discrepancies not intercepted by pharmacy, and ensure appropriate remediation is completed when discrepancies are identified.

Data monitored will include date of review, patient name, date of birth, medical record number, accuracy of discharge medication orders, pharmacy staff completing the review, and documentation of identified discrepancies

and corresponding remediation actions.

Pharmacy Leadership will be responsible for conducting the audits and reviewing results. 30 audits will be conducted monthly for 2 months to evaluate discharge medication order accuracy and documentation completion, with a goal of 90% compliance (compliance defined as accurate discharge medication orders with no actionable follow ups). This will be followed by 15 audits conducted monthly for 1 month, with a goal of 95% compliance. After that period, 10 audits will be conducted monthly for 1 month, with a goal of 100% compliance to ensure sustained accuracy and compliance. 5 monthly random audits will be done ongoing indefinitely to support sustained compliance.

Audit results will be compiled and reported by Pharmacy Leadership to the Quality Department on a monthly basis. Findings, trends, and identified opportunities for improvement will be presented to the Quality Committee at its regularly scheduled bimonthly meetings and the Director of Hospital Medicine will work with physicians directly. Results will also be shared with Hospital Medicine and other relevant stakeholders as appropriate to support accountability, targeted education, and ongoing performance improvement.

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A 799	Continued From page 11 assigned a social worker (SW) and CM upon admission to the hospital. The SW was responsible for completing the initial assessment of the patient, which included the patient's prior living situation, their social history, prior level of assistance needed for ADLs, if others lived with the patient that helped with their care, and if there were any known barriers to their ability to return to their prior living situation. The information gathered was documented and shared with the patient's medical team. Rounds (organized meetings by a healthcare team to discuss patient progress, review test results, and formulate or update a management plan) were completed daily and were to be attended by as many of the patient's medical team as possible. Referrals to nursing homes, ALCs, home health services, or other therapy services were made based on the patient's needs obtained by the assigned SW and medical team. The assigned CM was responsible for ensuring the patient's needs were addressed once the SW had completed the patient's initial admission assessment. Discharge planning began as soon as the patient was admitted to the facility. The assigned CM met with the patient and (if possible) their family members to discuss discharge preferences. If the patient had come from an ALC or a nursing home, their nursing staff would be contacted and informed of the patient's progress and discharge plans. The goal was to have the patient return to the ALC or nursing home based on their needs. The determination of when a patient was ready for discharge was based on the patient's needs and the recommendations of the patient's physician. If a facility expressed safety concerns	A 799			

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A 799	Continued From page 12 for the ability to care for the patient, most facilities would do an on-site evaluation of the patient at the hospital before accepting them back into their care. The hospital struggled with some facilities (including ALCs) not wanting to take patients back. If there were continued concerns between the receiving facility and the hospital, the ombudsman was contacted to assist. She was not aware of an instance when a patient being discharged from the hospital to the receiving facility had refused to take the patient back or had continued safety concerns for the patient. To her knowledge, the hospital did not have a policy or procedure to follow regarding the discharge of patients. They relied on experience as to what steps needed to be taken for the safe discharge of a patient. If a patient was living in an ALC before their hospitalization and that facility voiced concerns about taking the patient back, she would want to know what barriers were preventing the patient from returning to their care so those concerns could be addressed. She expected the CMs to document any conversations that took place with the receiving facility staff, especially if they opposed the patient returning to their facility. If a patient were to be discharged from the hospital, she expected all discharge orders to be reviewed and reflected within the discharge instructions. If there were missing orders within the discharge instructions, she expected that to be caught before the patient was discharged from the hospital. She was unaware that patient 5's Eliquis order, home health services, and therapy orders were not included in his discharge instructions, but they should have been.	A 799			

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A 799	Continued From page 13 She agreed that patient 5 had many risk factors, including a recent brain bleed, was at continued high risk for falling, had agitation, poor safety awareness, was withdrawing from alcohol and nicotine, was restrained and required 1:1 staff supervision while hospitalized, and a new antipsychotic medication was recently added. She confirmed his discharge back to the ALC was a concern. When a copy of the provider's revised January 2024 Patient Discharge or Transfer to Another Acute Care Facility policy was reviewed by RN CM manager C, she stated it was in place before she started in her position a year ago. She did not agree with the policy, which stated that the discharge policy/procedure did not apply to patients returning to a nursing home or an ALC. 4. Interview on 4/1/26 at 10:25 a.m. with MD, ALC primary care provider H revealed she was familiar with patient 5 and was his primary care physician since he was admitted to his home at the ALC. She reviewed his discharge information from the hospital. According to the information included in his discharge summary, he required skilled nursing services. Those required services could not be provided at an ALC. She would consider those services to be over the level of care an ALC facility could provide. 5. Interview on 4/1/26 at 10:35 a.m. with LSW D revealed she had worked as an LSW at the hospital for 2 months. The SWs were responsible for completing the initial admission assessment of the patients once the SWs were assigned to them. They collected information about their past that included social history, any prior services they received, confirmed their current level of	A 799			

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A 799	Continued From page 14 care, and any other relevant information about their prior needs. That assessment information was documented and shared with the patient's medical team members. The SWs then passed the patient off to the CM, but were available if there were needs that could not be addressed by the assigned CM. The SWs attended the length of stay meetings to keep informed of the progress of the patient. The SW did not usually communicate with the nursing home or ALC staff; the CMs did that. The PASRR assessments were not completed by the SW staff; they were completed by the float CMs. They would check with the patients personally once a week to ensure their needs were being met. 6. Interview on 4/1/26 at 11:00 a.m. and again at 2:05 p.m. with RN CM E revealed she had worked as an RN CM for one year with the hospital. Once she was assigned to a patient, she tried to meet them within 24 hours of their admission to the hospital. Discharge planning was discussed right away to see what their preference was for where they would like to be discharged. If the patient was from a nursing home or an ALC, they expected the facility to readmit the patient. She reached out to the patient's receiving facility to discuss their discharge plans. If there was resistance from the facility to taking the patient back, she checked with therapy to ensure the patient was ready to be discharged. If there were continued concerns from the receiving facility, she checked again with therapy to ensure the patient was deemed ready to discharge and checked in with the patient and their family that they agreed with the patient's discharge plan. They would get the ombudsman involved if necessary to resolve the situation. If the patient was back to their baseline level of	A 799			

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A 799	Continued From page 15 care, she was trained that the patient was expected to go back to the ALC. If there was an ALC that refused to take back the patient, she would not send the patient back under those circumstances. On 2/11/26, patient 5 was deemed medically ready for discharge from the hospital. She attempted to contact the nurse at his former ALC but was informed she was out of the facility and would not return until 2/16/26, so he remained at the hospital. On 2/16/26, the ALC nurse had requested to review patient 5's medical records before agreeing to take him back. Those records were sent by fax to his ALC as requested. A call was received from the ALC saying they agreed to take him back if transportation was arranged. RN CM E was responsible for ensuring discharge instructions were reviewed for accuracy before discharge. She confirmed she had reviewed the physician's discharge orders. She acknowledged that he had just had a brain bleed, was at high risk for falling, was going through withdrawal from alcohol and nicotine, was impulsive, had recently been restrained due to agitation, was getting 1:1 staff supervision due to poor safety awareness, was placed on an antipsychotic medication for mental health concerns before his discharge, and would be returning to an ALC that did not provide skilled nursing care. During her review of the discharge orders, she had failed to recognize an order for an anti-coagulant medication, and orders for home health and therapy services were not included in the discharge instructions. Home health services were not available in the area where patient 5 lived, and she had failed to document that in his	A 799			

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A 799	Continued From page 16 medical record. She acknowledged that although home health services were not available on an outpatient basis, arrangements for needed services could have been made if he had been placed in a skilled living facility. 7. Interview on 4/1/26 at 3:30 p.m. with RN A regarding patient 5's discharge revealed: *It was apparent that there was missed communication internally amongst the IDT on the discharge of this patient. *Even though the ALC had eventually accepted him back to their facility, it was clear that he required a higher-skilled level of care and oversight for his safety, well-being, and rehabilitation needs. *She was not aware that the LSWs had minimal involvement with the discharge process and would have expected them to be more involved to ensure proper placement occurred for the patient's well-being. *She was not aware that the CM team did not have a policy and process in place to determine the proper placement of a patient. They should not have been relying on "what they knew or know." *There were several staff that should have reviewed the patient's final discharge orders to ensure they were all carried through. She agreed those missed orders for continued physical therapy, and Eloquis, were concerning and created the potential for safety concerns for the patient. 8. Review of the provider's undated Patients' Rights and Responsibilities pamphlet that was provided to the patients upon admission revealed that the patients were told about care alternatives when hospital care was no longer appropriate.	A 799			

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A 799	Continued From page 17 "When medically proper and legally permitted, or on your request, you may be transferred to another facility. Avera will work with patients to address discharge planning needs. If, at any time, you or your representative sees a need for more in-depth discharge planning or you wish to review your specific discharge plans, feel free to discuss with your team." Review of the provider's revised January 2024 Patient Discharge or Transfer to Another Acute Care Facility revealed "Patients are discharged from the hospital or transferred to another level of care based on the patient's assessed needs. Plans for discharge or transfer are facilitated by an interdisciplinary team, as appropriate to the patient's needs. The discharge/transfer process does not apply to assisted living, long-term care (LTC), or skilled nursing care dispositions when being discharged from the hospital." Review of the provider's undated Social Worker job description revealed "The main focus of the Social Worker is to assist in meeting the psychosocial/continuum of care needs of the patient and family to ensure optimum functioning. In addition to direct care services, the Social Worker shall have duties of consultation, education, policy and program planning, performance improvement tasks, advocacy, and liaison with the community. Evaluates data gathered in terms of the medical plan of treatment, available social service programs, financial counseling, and plans a pertinent therapy program that will provide maximum benefits and safety for each patient. Works collaboratively with clinical coordinators, physicians, and other members of the care team in providing coordinated services, which	A 799			

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A 799	Continued From page 18 facilitates continuity of care for the patient." Review of the provider's undated RN-Case Manager job description revealed "Collaborates with the multidisciplinary care team to bring together an established plan for patient treatments, assists with the transitions between levels of care, to promote the best possible patient outcome. The case manager facilitates efficient utilization of resources and identifies patient care needs throughout the continuum of care." Review of the provider's March 2023 Provider Orders policy revealed "Provider orders are used to communicate to the health care team all medical, nursing, and ancillary treatments, procedures and modalities. The goal is to provide safe, accurate and timely implementation of provider orders. The nurse or qualified ancillary staff acknowledges the electronic order confirming receipt of the order and verifying appropriate measures have been taken to ensure proper and prompt execution of the order." DISCHARGE PLANNING PROGRAM REVIEW CFR(s): 482.43(a)(7)	A 799			
A 803	The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were admitted within 30 days of a previous admission, to ensure that the plans are responsive to the patient post-discharge needs. This STANDARD is not met as evidenced by: Based on interview and document review, the provider failed to ensure the patient's discharge	A 803	On April 7, 2026, Accreditation, the Care Transitions Director, and the Case Management Manager met to review survey findings, current processes, and policy alignment. A root cause analysis identified gaps in staff knowledge and understanding of CMS Conditions of Participation (CoPs), as well as inconsistencies in process implementation and the organization's ability to effectively evaluate and improve its discharge planning program. Corrective actions included development and implementation of standardized discharge planning tools and processes to improve consistency and compliance. On April 9, 2026, the Accreditation Manager distributed a discharge audit tool and standardized discharge algorithm to Case Management and Social Work leadership. These tools were used to guide development of staff reference materials, support consistent discharge planning		6/5/26

workflows, and strengthen documentation practices across the interdisciplinary team.

Additional corrective actions include development of Discharge/Readmission Chart Audits policy, enhanced staff education, and implementation of structured audit processes to ensure ongoing evaluation of discharge planning effectiveness and alignment with regulatory requirements.

To identify other potentially affected patients, retrospective and ongoing reviews of a representative sample of discharged patient records will be conducted. These reviews will focus on evaluating discharge planning processes, including timeliness of assessments, alignment of discharge disposition with patient needs, and completeness of documentation. Particular attention will be given to patients discharged to post-acute care settings and those readmitted within 30 days to determine whether discharge plans were responsive to patient needs.

Findings from these reviews will be used to identify any additional patients impacted by similar process gaps. Identified issues will be addressed through appropriate follow-up, including provider and staff education, process reinforcement, and incorporation into ongoing performance improvement activities to ensure sustained compliance and prevent recurrence.

On 4/7/26, Accreditation, the Care Transitions Director, and the Case Management Manager met to review survey findings, current processes, and policy alignment. A root cause analysis identified gaps in staff knowledge and understanding of CMS Conditions of Participation (CoPs), as well as inconsistencies in process implementation and the ability to evaluate and improve its discharge planning program.

On 4/9/26, the Accreditation Manager distributed a discharge audit tool and standardized discharge algorithm to Case Management and Social Work leadership to guide development of staff reference materials and strengthen consistency in discharge planning and documentation practices.

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

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 430016	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/01/2026
NAME OF PROVIDER OR SUPPLIER AVERA MCKENNAN HOSPITAL & UNIVERSITY HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1325 S CLIFF AVE SIOUX FALLS, SD 57117		
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A 803	Continued From page 19 planning process was evaluated regularly by reviewing a representative sample of discharged patients' closed medical records to identify the effectiveness of the plan, the provider's responsiveness to patients' post-discharge needs, and to modify the discharge process based on identified trends by one of one case manager (CM) C. Findings include: 1. Interview on 4/1/26 at 8:00 a.m. with CM C regarding the discharge planning chart review process revealed she oversaw the patient chart reviews, but there was no process or policy in place for the staff to use as guidance. She had completed "some here and there, or as time had allowed." She was unaware of the federal requirements and regulations that required a facility to complete periodic reviews of the patient charts and their discharge plans to ensure all their needs were met upon discharge from the hospital. Nor was she aware that patients with hospital readmissions within 30 days required chart reviews. She was in the manager role for approximately 2 years and during that timeframe, had completed a "few random reviews." 2. Review of CM C's patient chart reviews for appropriate discharge planning revealed that one chart review was completed for the year 2024 on October 15th. Seven patient chart reviews had been completed for the year 2025. There was not any patient chart reviews to support that the facility had a discharge planning process in place for any patients since July 2025. 3. Interview on 4/1/26 at 3:30 p.m. with the senior director for medical support services A and	A 803	To achieve sustained compliance, system-level changes include the development and implementation of standardized discharge planning tools and processes to improve consistency and compliance. The discharge audit tool and standardized discharge algorithm have been implemented to promote consistent discharge planning workflows and strengthen documentation practices across the interdisciplinary team. Structured audit processes have been established to support ongoing evaluation of discharge planning effectiveness and alignment with regulatory requirements. Sustained compliance is further supported through retrospective and ongoing review of discharged patient records, with a focus on timeliness of assessments, alignment of discharge disposition with patient needs, and completeness of documentation, particularly for patients discharged to post-acute care settings and those readmitted within 30 days. Findings from these reviews are used to identify trends and opportunities for improvement, with targeted education, process reinforcement, and integration into ongoing performance improvement activities to ensure continued compliance and prevent recurrence. Education was provided to staff on June 5th, 2026 including targeted education on the PASRR policy, Discharge Checklist, Post-Acute Placement Concern Escalation policy, and DOH findings related to CoPs A-0799 and A-0803. Staff signed an attestation acknowledging receipt of the education and understanding of expectations. Case Management Leadership will validate the discharge planning process through structured auditing of a representative sample of discharged patient records. Data monitored will include alignment of discharge disposition with patient clinical needs, completeness and accuracy of discharge orders and instructions, inclusion of medications, and arrangement of		

required post-discharge services (e.g., therapy, home health). Audits will also include review of patients readmitted within 30 days to evaluate the effectiveness of the discharge plan and responsiveness to post-discharge needs.

15 readmission audits will be conducted monthly for 90 days to evaluate discharge planning effectiveness, with a goal of 100% compliance. After that period, 12 audits monthly or 10% of fiscal year average will be conducted to ensure sustained effectiveness. After the initial monitoring period the number of audits will be reevaluated every fiscal year and adjusted by census and to meet CoPs.

Audit findings will be aggregated and trended to identify gaps in discharge planning practices, variation in staff performance, and barriers to meeting patient needs. Identified discrepancies will result in immediate remediation, including staff education, process reinforcement, and leadership follow-up.

Audit results will be compiled and reported by Case Management and Quality Leadership to the Quality Department monthly. Findings, trends, and corrective actions will be presented to the Quality Committee at its every two months meetings and shared with other relevant committees and stakeholders, including Care Transitions and Hospital Medicine leadership, to support accountability and continuous improvement.

Monitoring outcomes will be incorporated into the organization's Quality Assessment and Performance Improvement (QAPI) program. The discharge planning process will be modified as needed based on audit findings and trends to ensure sustained compliance with CMS Conditions of Participation and prevent recurrence of identified deficiencies.

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A 803	Continued From page 20 accreditation manager B revealed they were unaware that periodic chart reviews were a federal requirement for discharged patients. To their knowledge, there was no policy in place for that process.	A 803			