PRINTED: 12/02/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		433442	B. WING		11/2	11/20/2024	
	ROVIDER OR SUPPLIER COUNTY RURAL HEAL	TH CLINIC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN MARTIN, SD 57551				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
J 000	INITIAL COMMENTS		J 000				
J 041	with 42 CFR Part 491 for rural health clinics 11/20/24. Bennett Co found not in complian requirements: J0041, and J162. PHYSICAL PLANT AICFR(s): 491.6(a) 491.6(a) Construction The clinic and the cer arranged, and mainta safety of patients, and for the provision of dir This STANDARD is r Based on observatio failed to ensure two of in the procedure room Findings include: 1. Observation on the revealed three oxyge room. One oxygen ta	unty Rural Health Clinic was ce with the following J0043, J0135, J160, J161, ND ENVIRONMENT It is constructed, index to insure access to and diprovides adequate space rect services. In and interview, the provider of three oxygen tanks, stored in, had been secured.	J 041	On November 20, 2024, the clinic was cited Tag J041 for failing to ensure proper storage oxygen tanks in the procedure room, where of three tanks were found unsecured on the against the wall. Immediate corrective actic taken on 11/20/24 to secure the tanks in conviting with the safety standards by the Maintenance of the oxygen storage policy will be reviewed updated to include detailed storage guideling the CEO or designee responsible for all pol updates and staff education. All staff will be on proper handling and storage procedures inspections, overseen by the Maintenance Supervisor, will be implemented by to ensucontinued compliance, with results reviewed monthly by Quality Assurance Performance Improvement (QAPI) committee which increpresentatives from each service area as we facility Medical Director monthly for 3 monthen proceed per findings and Committee recommendations.	te of two out floor on was mpliance Manager. It and hes, with icy e trained Weekly here and he well as the	12/30/2024	
J 043		at 11:55 with chief vealed she had not been aks had not been secured in	J 043				
		reventive maintenance Supplier REPRESENTATIVE'S SIGNATURE					
ABURATORY	DIKACTOR'S ORIPROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	11 C. L. C.	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		433442	B. WING		11	/20/2024	
	ROVIDER OR SUPPLIER COUNTY RURAL HEAD	LTH CLINIC	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN MARTIN, SD 57551				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
J 043	Based on observation interview, the provided dates of biologicals a patient safety through include: 1. Observations made an	nd biologicals are and not met as evidenced by: on, policy review, and er failed to monitor expiration and supplies to ensure hout the building. Findings le during the morning of ls and supplies in rooms one, two, three, four, cedure room; the hallway e laboratory revealed the ble for patient or staff use: tile of Hibiclens (chlorhexidine ur % w/v [weight/volume]) bial skin cleanser) expired ttle of Hibiclens expired 9/20. ackages of lubricating jelly le of Aplicare tion (antiseptic) expired 1/19. ottles of Hibiclens expired inges of 0.85% Sodium e) USP intravenous flush	J 043	On November 20, 2024, the clinic was Tag 491.6(b)(2) for failing to monitor e of biologicals and supplies throughout tompromising patient safety. Immediatactions included removing and properly expired biologicals and supplies from e the procedure room, the laboratory, and supply closet as of 11/21/24. Developm approval of a new policy for monitoring and supplies will be finalized, with the designee responsible for all policy upda education. All staff will receive training updated policy and procedures for invermanagement and monitoring. Monthly checklists of all storage and supply area implemented, conducted by clinic staff by the Clinic Manager. Results of these will be reviewed monthly by QAPI Commonths, and then proceed per findings a recommendations.	expiration dates the building, a corrective discarding all sam rooms, the hallway ent and biologicals CEO or the same staff on the tory aspection in sull be and overseen inspections unittee for 3		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2.5	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		433442	B. WING_			11/	20/2024	
	ROVIDER OR SUPPLIER COUNTY RURAL HEALT	TH CLINIC		STREET ADDRESS, CITY, STATE, ZIP COD 102 MAJOR ALLEN MARTIN, SD 57551	ΣE		EUIZUET	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
	*Five single use pack- expired 7/18. e. Exam room five: *One four-ounce bottle *Three Hemocult (fec- cards expired 1/21. f. Exam room six: *One eight-ounce bottle *Two four-ounce bottle *One eight-ounce bottle *One package of Skin expired 7/22. *Four single use pack- expired 7/18. *One package Vyaire Surelock clips (used for electrocardiograms [E *One package Kendal Electrodes (used for p 9/20/21. *One package Kendal Electrodes (used for p 6/9/24. *Eleven packages of F diagnostic electrodes (expired 6/19/22. *One four-ounce bottle povidone-iodine solutio *One bottle of Sodium 100 ml solution expired *One bottle of Curity P inch bandage material	e of Hibiclens expired 6/24. al occult blood) stool testing the of Hibiclens expired 4/22. es of Hibiclens expired 6/24. the of Skin Tegrity Wound 5/24. ottles of Hibiclens expired Prep Protective wipes ages of lubricating jelly Connector Clip DLAR or performing KGJ) expired 6/5/20. I 5400 Diagnostic Tab erforming EKGs) expired I 5400 Diagnostic Tab erforming EKGs) expired Chilips Solid Gel disposable (used for performing EKGs) e of Aplicare on expired 1/19. Chloride Irrigation USP d 9/3/23. Iain Packing Strip 1/4 X 15 expired 12/20. es of sterile water expired		43				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION		(X3) DATE SURVEY	
		IDENTIFICATION NOMBER.	A. BUILDII	NG		COMPLETED	
		433442	B. WING_			11/20/2024	
BENNET	PROVIDER OR SUPPLIER T COUNTY RURAL HEAL			STREET ADDRESS, CITY, STATE, ZIP COD 102 MAJOR ALLEN MARTIN, SD 57551	£	11/20/2024	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
J 043	*One box containing of speculums expired 9// *One box containing of speculums expired 11 *One box containing of speculums expired 11 *One box containing of speculums expired 11 *One box containing solubricating jelly expired i. Laboratory: *One container of Sier dipsticks (used for the patient urine specimer *One container of Hen (used for the determin patient blood specimer *Ten Thin Prep Pap Te expired 3/9/24.	Opb ER-Spec, size medium, 14/23. Opb ER-Spec, size medium, /11/23. Opb ER-Spec, size large, /4/24. single use packages of d 11/1/22. mens Multistix 10G chemical examination of ns) expired 9/30/24. no Point H2 testing strips ation of hemoglobin in	Jo	043			
J 135	provider had not developolicy that addressed to dates of biologicals and Interview on 11/20/24 a executive officer A reversible was unaware of the clinic. *She confirmed the clinipolicy for monitoring expolicy for monitor	at 11:55 AM with chief caled: he expired supplies in the nic had not developed a copiration dates of s. ICES d 491.9(c)(2)	J 13	35			

MARE OF PROVIDER OR SUPPLIER BENNETT COUNTY RURAL HEALTH CLINIC STREET ADDRESS, CITY, STATE, ZIP CODE 102 MARTIN, 3D 57551 JOA 1D GEACH DEFORMATION OR LSC IDENTIFYING INFORMATION) J 1335 Continued From page 4 (2) of this section apply to RHCs, (2) Laboratory. These requirements apply to RHCs The RHC provides laboratory services in accordance with part 493 of this chapter, which implements the provisions of section 353 of the Public Health Service ACt. The RHC provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, including: (i) Chemical examinations of urine by stick or tablet method or both (including urine ketones); (ii) Henoglobin or hematocit; (iii) Blood glucose; (iv) Examination of stool specimens for occult blood; (v) Pregnancy tests; and (vi) Primary culturing for transmittal to a certified laboratory. This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to ensure one of six laboratory tests; coregnancy tests, and treatment append to QAT or time tests in the clinic or six provider failed to ensure one of six laboratory tests; coregnancy tests, and committee committee monthly for 3 months, and then proceed per findings and Committee recommendations. STREET ADDRESS, CITY, STATE, ZIP CODE 102 MARTIN, 3D 57551 MARTIN, 3D 57551 D PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CORRECTIVE THE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CORRECTIVE THE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CORRECTIVE THE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CORRECTIVE THE ACTION SHOULD BE CORRECTIVE THE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE ACTION SHOULD BE CARCH CORRECTIVE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALL EN MARTIN, SD 57551			433442	B. WING	_				
Summary statement of Deficiencies 102 MAJOR ALLEN MARTIN, SD 57551	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS CITY STATE ZIP CODE	111	/20/2024	
PREFIX TAG GEACH DEFICIENCY NO ILSC IDENTIFYING INFORMATION) J 135 Continued From page 4 (2) of this section apply to RHCs,	BENNETT	COUNTY RURAL HEALT	'H CLINIC	30	1	02 MAJOR ALLEN			
On November 20, 2024, the clinic was cited under CFR 91.9(a)3 and 491.9(c)2 Direct failing to ensure the availability of urine pregnancy tests, a required laboratory. These requirements apply to RHCs The RHC provides laboratory services in accordance with part 493 of this chapter, which implements the provisions of section 353 of the Public Health Service Act. The RHC provides basic laboratory services essential to the immediate diagnosis and treatment of the patients, including: (i) Chemical examinations of urine by stick or tablet method or both (including urine ketones); (ii) Blood glucose; (iv) Examination of stool specimens for occult blood; (v) Pregnancy tests; and (vi) Primary culturing for transmittal to a certified laboratory. This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to ensure one of six laboratory tests (pregnancy tests) essential for immediate diagnosis and treatment had been made available to the patients served by the clinic. Findings include: 1. Observation on 11/20/24 at 9:05 AM in the clinic's laboratory revealed no urine pregnancy test kits were available for frapatient testing.	PREFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
physician assistant B revealed the hospital laboratory staff processed most laboratory requests. He did not think the clinic had any urine		(2) of this section app 491.9(c) Direct services (2) Laboratory. These RHCs The RHC in accordance with pai implements the provise Public Health Service basic laboratory service immediate diagnosis a including: (i) Chemical examinatablet method or both (ii) Hemoglobin or he (iii) Blood glucose; (iv) Examination of stoblood; (v) Pregnancy tests; a (vi) Primary culturing to laboratory. This STANDARD is not Based on observation failed to ensure one of (pregnancy tests) essed diagnosis and treatment available to the patient Findings include: 1. Observation on 11/2 clinic's laboratory reveatest kits were available laboratory staff process	requirements apply to provides laboratory services at 493 of this chapter, which ions of section 353 of the Act. The RHC provides see essential to the and treatment of the patient, ations of urine by stick or (including urine ketones); matocrit; bol specimens for occult and for transmittal to a certified of the met as evidenced by: and interview, the provider six laboratory tests ential for immediate and been made as served by the clinic. 0/24 at 9:05 AM in the aled no urine pregnancy for patient testing. during the survey with evealed the hospital sed most laboratory	J	135	On November 20, 2024, the clinic was cited CFR 491.9(a)(3) and 491.9(c)(2) for failing the availability of urine pregnancy tests, a relaboratory service essential for immediate dand treatment. Immediate corrective action on 11/21/24 by obtaining and stocking urine pregnancy test kits in the clinic. A new policimplemented to ensure the consistent availa all required laboratory supplies in the clinic including urine pregnancy tests. The CEO of designee will be responsible for all policy up and staff education. Staff will be trained on updated policy and the importance of maintreampliance with laboratory service requirent Routine monthly inventory checks of urine the clinic, overseen by the Clinic Manager, conducted and reported to QAPI Committee for 3 months, and then proceed per findings	to ensure equired iagnosis was taker e cy will be bility of r pdates the aining nents, tests in will be		

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	O TON MEDICARE &	WEDICAID SERVICES			OMB N	O. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENNETT	COUNTY RURAL HEAL	TH CLINIC	1	102 MAJOR ALLEN		
				MARTIN, SD 57551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
J 135	Continued From page	5	J 135			
	executive officer A reviews had been performed to performed the biennial program evaluation performed to performed the performed to performed the performed to pe	pospital laboratory collected tient specimens for ulred by the clinic. Frame the clinic did not have in the clinic. FION Aduation. Fiot met as evidenced by: Fecord review, and policy illed to ensure policies and established and mobiennial (every two attions. Findings include: Findings include	J 160	On November 20, 2024, the clinic was §491.11 for failing to establish and imp and procedures to perform biennial pro evaluations as required. Corrective acti initiated to draft and adopt a compreher detailing the process, timeline, and resp conducting biennial program evaluation assessments of services, implementation and procedures, patient record reviews, reports with recommendations. The CE will be responsible for all policy update education. Leadership will conduct an i evaluation to address the gap, identify i and align with compliance requirements receive training on the new policy and eprocedures. A schedule for regular eval implemented to ensure ongoing compliar results reviewed by QAPI Committee m months, and then proceed per findings a recommendations.	plement policie gram on will be usive policy consibilities for so, including n of policies and summary O or designee as and staff nitial program intial prog	

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	to FOR MEDIONINE G	I DIONID OLIVICES			OMB NO. 0938-	-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		433442	B. WING		11/20/2024	1
BENNETT	PROVIDER OR SUPPLIER COUNTY RURAL HEAL			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN MARTIN, SD 57551	1112012024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	TION
	and procedures. *Had reviewed open a records. *Had reviewed a sum recommendations for Refer to J161. *Had determined if ch related policies were clinical privileges neer recommendations had addressed by leaders Refer to J162. PROGRAM EVALUAT CFR(s): 491.11(a)-(c) § 491.11 Program even (a) The clinic or center for, a biennial evaluation including at least the mand the volume of sense (2) A representative seclosed clinical records (3) The clinic's or center (c) The purpose of the whether: (1) The utilization of sense (2) The purpose of the whether:	and closed patient medical mary report with improvement, if necessary. anges in patient care needed or if supervision or ded to be made, or if deben made and hip. TON raluation. r carries out, or arranges on of its total program. udes review of: inic or center services, number of patients served vices; ample of both active and		On November 20, 2024, the clinic was cited \$491.11 for failing to conduct biennial evaluits total program as required. To address this deficiency, the clinic will implement the fol corrective actions. A policy and procedure f conducting biennial program evaluations will developed, specifying who will perform the evaluation, the timeline, and the methodolog evaluation will include a review of clinic sei utilization (including patient volume and typ services provided), a representative sample of active and closed patient records, and the clinealthcare policies. The CEO or designee wiresponsible for all policy updates and staff e Leadership will complete an initial evaluation establish a baseline and determine whether sutilization is appropriate, policies are being and any changes are needed. Staff will be trathenew policy and evaluation process to ensongoing compliance. A schedule for regular evaluations will be implemented to ensure or compliance, with results reviewed by QAPI Committee monthly for 3 months, and then per findings and Committee recommendation	actions of sowing or all be sy. The vice ees of of both nic's ll be ducation. In to ervice followed, ined on the proceed or occeed.)24
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
		433442	B. WING		44	/20/2024	
NAME OF E	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 17	120/2024	
BENNET	T COUNTY RURAL HEAL	TH CLINIC .		102 MAJOR ALLEN MARTIN, SD 57551			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
J 161	Continued From page	7	J 16	11			
	(3) Any changes are in This STANDARD is in Based on interview a provider failed to: *Identify who was to pevaluations nor how obe done. *Evaluate the types are "Assess the implement procedures. *Review open and clorecords. *Take any needed corrany changes to policies care services offered by Findings include: 1. Interview on 11/20/2 executive officer A review had been required. *She was unaware the had been required. *She was unaware of the biennial program expended there is evaluation performed services officer and the services officer executive of the executive	needed. not met as evidenced by: not lack of records, the erform the program r when the evaluation would not services provided. Intation of policies and sed patient medical rective actions, or to make s and procedures or patient piennially (every two years). 24 at 11:5 AM with chief evaluation. and not been a program esince she had started as	J 16				
	had been performed in	previous years.					
J 162	There were no records the provider had perfor evaluations. PROGRAM EVALUATI CFR(s): 491.11(d)		J 162				
	491.11(d) The clinic or findings of the evaluation action if necessary.	center staff considers the on and takes corrective					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MAME OF PROVIDER OR SUPPLIER BENNETT COUNTY RURAL HEALTH CLINIC SUMMANY STYCEMENT OF DEFICIENCIES (EACH CORRECTION SHOULD BE COMPRISHED THE PRECESSED BY FULL REGULATORY OR 150 IDENTIFYING INFORMATION) J 162 Continued From page 8 This STANDARD is not met as evidenced by Based on interview, record review, and policy review, the provider failed to: Assess the overall rural health clinic program. Identify needs or areas to improve. Take any needed changes to the patient care services offered biennially (every two years). Findings include: 1. Interview on 11/20/24 at 11:5 AM with chief executive officer A revealed: She was unaware that a review of clinic services was required. She was unaware that a review of clinic services was required. She was not aware of any policy or procedure for the biennial program evaluation. She confirmed there had not been a program evaluation performed since she had started as chief executive officer reafter that year. She was not aware of any other evaluations that had been performed in previous years. There were no records or policies that indicated the provider had performed biennial program evaluations or "If changes in policies were necessary." If training of staff was necessary. "If changes in policies were necessary." If training of staff was necessary." If training of staff was necessary. "If changes in policies were necessary." If training of staff was necessary." If training of staff was necessary. "If changes in policies were necessary." If training of staff was necessary. "If changes were necessary in the areas of supervision or clinical privileges. "Where and when the evaluation findings and recommendations when leadership did not take the corrective actions recommended as a result of the evaluation or if different actions were taken than those recommended.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
BENNETT COUNTY RURAL HEALTH CLINIC (X4) ID SUMMARY STATEMENT OF DEFICIENCY TAG J 162 Continued From page 8 This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to: "Assess the overall rural health clinic program. "Identify needs or areas to improve. "Take any needed corrective actions, or make any needed changes to the patient care services offered bennially (every two years). Findings include: 1. Interview on 11/20/24 at 11:5 AM with chief executive officer A revealed: "She was unaware that a review of clinic services was required. "She was not aware of any other evaluation. "She confirmed there had not been a program evaluation performed since she had statred as chief executive officer earlier that year. "She was not aware of any other evaluations that had been performed in previous years. There were no records or policies that indicated the provider had performed biennial program evaluations or "If changes in policies were necessary," "If training of staff was necessary," "If changes were necessary," "If was necessary in the areas of suppervision or clinical privileges, availations when leadership did not take the corrective actions recommended as a result of the evaluation or if different actions were			433442	B. WING		14	120/2024	
PREFIX TAG J162 Continued From page 8 This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to: "Take any needed corrective actions, or make any needed changes to the patient care services offered biennially (every two years). Findings include: 1. Interview on 11/20/24 at 11:5 AM with chief executive officer A revealed: "She was not aware that a review of clinic services was required. "She was not aware of any policy or procedure for the biennial program evaluation. "She confirmed there had not been a program evaluation performed since she had started as chief executive officer earlier that year. "She was not aware of any other evaluations that had been performed in previous years. There were no records or policies that indicated the provider had performed biennial program evaluations or "If changes in policies were necessary." "If training of staff was necessary." "If changes were necessary in the areas of supervision or clinical privileges. "Where and when the evaluation findings and recommendations were considered and by whom." Rationale for decisions when leadership did not take the corrective actions find not take the corrective actions for the patient care services and staff reducation. Leadership will be implemented. Staff will be trained on the new policy by 1/4/2025 to ensure understanding and compliance. A schedule for regular evaluations will be implemented to ensure opportune of the provider had performed biennial program evaluations or "If changes were necessary." "If training of staff was necessary." "If changes were necessary in the areas of supervision or clinical privileges. There were no records or policies that indicated the provider had performed biennial program evaluations were considered and by whom. "Rationale for decisions when leadership did not take the corrective actions recommended as a result of the evalu	BENNETT	COUNTY RURAL HEALT			102 MAJOR ALLEN MARTIN, SD 57551		20/2024	
This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to: "Assess the overall rural health clinic program. "Identify needs or areas to improve. "Take any needed corrective actions, or make any needed changes to the patient care services offered blennially (every two years). Findings include: 1. Interview on 11/20/24 at 11:5 AM with chief executive officer A revealed: "She was unaware that a review of clinic services was required. "She was not aware of any policy or procedure for the biennial program evaluation. "She confirmed there had not been a program evaluation performed since she had started as chief executive officer earlier that year. "She was not aware of not been a program evaluation performed in previous years. There were no records or policies that indicated the provider had performed biennial program evaluations or "If changes were necessary. "If changes ene necessary. "If changes ene necessary in the areas of supervision or clinical privileges. "Where and when the evaluation findings and recommendations were considered and by whom. "Rationale for decisions when leadership did not take the corrective actions as necessary and the following corrective actions as included to the collowing or address this, the clinic will implement following corrective actions. A formal policy and procedure for reviewing evaluation findings and determining necessary corrective actions. The CEO or designee will be established. This policy will outline responsibilities, include will be established. This policy will outline responsibilities, including who will review findings, how decisions will be documented, and timelines for implementation of conduct an initial review of clinic operations, identify wrans for documenting evaluation. The CEO or designee will be established. This policy will outline responsibilities, includes and staff deuctions. The CEO or designee will be established. This policy of continuence responsibilities, indentify who wil	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	BE	COMPLETION	
		This STANDARD is in Based on interview, in review, the provider fat *Assess the overall ru *Identify needs or area *Take any needed con any needed changes to offered biennially (ever include: 1. Interview on 11/20/2 executive officer A review officer A review as unaware the was required. *She was not aware of the biennial program et evaluation performed schief executive officer. *She was not aware of the biennial program et evaluation performed in the term of the provider had performed in the provider had per	and met as evidenced by: record review, and policy ailed to: ral health clinic program. as to improve. rective actions, or make to the patient care services ary two years). Findings 24 at 11:5 AM with chief ealed: at a review of clinic services of any policy or procedure for evaluation. had not been a program since she had started as earlier that year. of any other evaluations that of previous years. as or policies that indicated med biennial program were necessary. seary in the areas of privileges. evaluation findings and e considered and by whom, as when leadership did not ons recommended as a or if different actions were	J 16:	§491.11(d) for failing to assess the findings biennial program evaluations and take correactions as necessary. To address this, the cli implement the following corrective actions. policy and procedure for reviewing evaluatifindings and determining necessary correcti will be established. This policy will outline responsibilities, including who will review if how decisions will be documented, and time implementation of corrective actions. The C designee will be responsible for all policy up and staff education. Leadership will conduct review of clinic operations, identify areas for improvement, and implement necessary chapatient care services, supervision, clinical prand staff training. A structured process for documenting evaluation findings, recommer leadership decisions, and actions taken will implemented. Staff will be trained on the new by 1/4/2025 to ensure understanding and con A schedule for regular evaluations will be implemented to ensure ongoing compliance, results reviewed by QAPI Committee month months, and then proceed per findings and	of ctive nic will A formal on ve actions indings, blines for EO or odates an initial runges to civileges, adations, be w policy mpliance.		

PRINTED: 12/02/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		433442	B. WING_		1	11/20/2024	
	PROVIDER OR SUPPLIER COUNTY RURAL HEAL	TH CLINIC		STREET ADDRESS, CITY, STATE, ZIP CODE 102 MAJOR ALLEN MARTIN, SD 57551	•	1120/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	CFR Part 491.12, Sub Preparedness require clinics, was conducted County Rural Health Compliance with the for E0042. Integrated EP Program CFR(s): 491.12(e) §416.54(e), §418.113(§460.84(e), §482.15(f), §485.625(f), §485.727 §486.360(f), §491.12(e) (e) [or (f)]Integrated health of multiple separately of that elects to have a unemergency preparedness may choose to particip system's coordinated exprogram. If elected, the unified a preparedness program following:] (1) Demonstrate that expected in the energency preparedness program following:]	ments for rural health d on 11/20/24. Bennett Clinic was found not in ollowing requirement: (e), §441.184(e), (e), §483.73(f), §483.475(e), (e), §485.542(f), (e), §485.920(e), (e), §494.62(e). Bealthcare systems. If a salthcare system consisting certified healthcare facilities infied and integrated easy program, the [facility] that in the healthcare emergency preparedness and integrated emergency preparedness and integrated emergency must- [do all of the each separately certified in actively participated in aunified and integrated easy program. maintained in a manner each separately certified each separately e	EO	Facility will review and modify the Preparedness Program (EP Program Rural Health Clinic (RHC) and achi program representative of all health offered. This will be the responsibil or designee, in conjunction with fac Officer and will be achieved by the 1. Clinic Manager or designee will program facilitated through involve emergency preparedness meetings a and participation in facility monthly Assurance Performance Improveme meetings. 2.CEO and Emergency Preparedness insure that circumstances unique to Clinic, its patient population, and se included in facility's unified EP Programmers and the integrated and unified EP Programmers that RHC staff are capable of the integrated and unified EP Program through RHC staff inclusion in EP Producation events, table top exercises simulated EP Program exercises. 4.CEO, or designee, in conjunction will perform an internal risk assessment will further guide the unified and integrated EP Program and procedures. These assessments will further guide the unified and integrated EP Program and procedures. These assessments what resources the RHC could offer Critical Access Hospital and/or the could of an emergency.	a) to integrate the leve a unified care systems ity of the CEO, illity EP Program following plan: participate in the lever preparedness ment at and education, Quality and (QAPI) sofficer will the Rural Health rvices are gram. sofficer will actively using an in compliance frogram sofficer will and "hands on" with EP Officer the unique to sed risk pproach to both. It development of m plan, policies will also identify to the facility's		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 1PH311

Facility ID: 433442

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		433442	B. WING_			111	/20/2024
	ROVIDER OR SUPPLIER COUNTY RURAL HEALT	TH CLINIC		1	STREET ADDRESS, CITY, STATE, ZIP CODE 02 MAJOR ALLEN MARTIN, SD 57551		2012024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	(3) Demonstrate that facility is capable of arintegrated emergency is in compliance [with (4) Include a unified a plan that meets the re (a)(2), (3), and (4) of transport integrated emergency on and include the following (i) A documented assessment, utilizing a approach. (ii) A documented assessment for eafacility within the healtrall-hazards approach. (5) Include integrated that meet the requirem (b) of this section, a coplan, and training and the requirements of pasection, respectively. This STANDARD is not be section, respectively. This STANDARD is not be section, and training and the requirements of pasection, respectively. This STANDARD is not be section, as of pased on interview and provider failed to address risk assessments in the emergency prepared not part of. Findings included the control of the part of a larger health is system's emergency probeen developed to addresservices offered, continues of a larger health is system's emergency probeen developed to addresservices offered and the control of the part of a larger health is system's emergency probeen developed to addresservices offered and the control of the part of a larger health is system's emergency probeen developed to addresservices and the part of a larger health is system's emergency probeen developed to addresservices and the part of a larger health is system's emergency probeen developed to addresservices and the part of t	each separately certified ctively using the unified and preparedness program and the program]. and integrated emergency quirements of paragraphs his section. The unified and plan must also be based owing: I community-based risk an all-hazards I individual facility-based ach separately certified his system, utilizing an policies and procedures sents set forth in paragraph pordinated communication testing programs that meet uragraphs (c) and (d) of this of met as evidenced by: I directord review, the sess its patient population, nuity of operations, and and community-based e health systems' sess program which it was a e: 4 at 11:55 AM with chief sealed the provider was a system. The health reparedness program had	E		Continued from page 1: 5.Integrated policies and procedures will be a by the CEO, or designee, in conjunction with Officer that will include the RHC in a coordi communication plan and training and testing programs. These policies and procedures will specifically address actions the clinic would be the event of an emergency. 6.Facility EP Program will be reviewed/update biannually, or whenever there is a change in some winternal or external hazards identified will be the responsibility of the CEO or designed the EP Officer. CEO or designee will present policies and prefor review as developed/modified and will recompliance of the above described unified an integrated EP Program monthly to facility QA committee, which includes representatives freservice area as well as the facility Medical Discrete in the program is the facility Medical Discrete in the program is the facility of the certain program is the facility Medical Discrete in the compliance of the above the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the facility Medical Discrete in the certain program is the certain program in the certain program in the certain program is the certain program in the certain program in the certain program is the certain program in the certain program is the certain program in the certain program in the certain pr	eake in ted services. This nee and occdures port d	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		433442	B. WING			1	1/20/2024
BENNETT	ROVIDER OR SUPPLIER COUNTY RURAL HEALT			10	TREET ADDRESS, CITY, STATE, ZIP CODE D2 MAJOR ALLEN IARTIN, SD 57551	<u>'</u>	112012024
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
E 042	the emergency preparency included any specific actions the cliric fan emergency. the emergency preparency included any specific actions the cliric fan emergency. There was no document in the cliric fan emergency.	redness plan. The plan had iffic information for the Health Clinic. rystem's emergency in revealed: ad not been identified or I health clinic, including nic would take in the event mentation identifying what uld offer to the attached	E	042			